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TENNCARE MEDICAID

AND

TENNCARE STANDARD

POLICY MANUAL

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TENNESSEE DEPARTMENT OF
HUMAN SERVICES

Helping shape Tennessee lives.

INTRODUCTION

The Medicaid program became law in 1965 as a jointly funded cooperative between the Federal and State governments to assist States in providing adequate medical care to eligible persons. In 1994 the State of Tennessee implemented a health care reform plan called TennCare. TennCare extended coverage to the Medicaid population and coverage to individuals who were determined to be uninsured or uninsurable, using a system of Managed Care Organizations (MCO). Coverage is referred to as TennCare Standard. Effective close of business April 29, 2005 new applicants are no longer eligible for TennCare Standard. Also effective close of business April 29, 2005, non-pregnant adults age 21 and older no longer qualify in the Medically Needy program.

Effective July 1, 2002, the Bureau of TennCare moved eligibility determination for TennCare Standard to the Department of Human Services (DHS). The Tennessee Department of Finance and Administration administers the State's TennCare program and contracts with the Department of Human Services to determine eligibility for more than 40 different Medicaid-eligible groups.

Applications for Medicaid may be obtained at the Department of Human Services with locations in each of Tennessee's 95 counties. Applications are available in English or Spanish and can be mailed, faxed, or taken to the local Department of Human Services office. Applications are also be filed on-line at the Department of Human Services website: www.state.tn.us/humanserv. After filing a signed application, an interview is scheduled with a caseworker. Certain documents may be requested to verify eligibility requirements. If an individual needs assistance in providing any of these items, assistance will be offered at the time of the interview. Applications are processed in 45 days.

There are two primary classifications of Medicaid: Categorically Needy & Medically Needy.

Categorically Needy

Families First cash assistance. This program is called TANF (Temporary Assistance to Needy Families) by the Federal Government. Eligibility is determined by DHS.

Medicaid Only (AFDC MO). Individuals who are ineligible for Families First because of a requirement that does not apply in Medicaid or who do not want to apply for the Families First program.

Pregnant Women. Available to pregnant women who do not qualify for Medicaid in any other category but would qualify for Families First/TANF if other children were in the home.

Transitional Medicaid. Medicaid is available for 12 months after a participant leaves the Families First/TANF program or is no longer eligible for AFDC-MO due to increased earnings or hours of employment. Must have received AFDC-MO for three of the last six months.

Newborns. Newborns are automatically eligible for one year after birth when born to a Medicaid eligible woman.

Recipients of Supplemental Security Income (SSI). Eligibility is determined by the Social Security Administration in Tennessee.

Caretakers of SSI Eligible Children. The caretaker of a child who qualifies for Supplemental Security Income (SSI) who would be eligible for Families First/TANF if the child did not receive SSI.

Poverty Level Income Standard for Pregnant Women and Children (PLIS). Pregnant women and certain children of a specified age (up to age 19) whose family gross income does not exceed the Federal Poverty Level Income Standard.

Women with Breast or Cervical Cancer. Residents of Tennessee who are uninsured, under age 65, and have been determined through the Centers for Disease Control (CDC) to need treatment for breast or cervical cancer, and are under the income limit of 250% of the Federal Poverty Level as determined by CDC.

Institutionalized individuals. Aged, blind, or disabled persons who would be eligible for SSI or Families First except for their institutionalization. Individuals receiving Home and Community Based Services (HCBS) are considered institutional.

SSI Pass-Along. Individuals who received Social Security benefits and SSI during the same month, but who no longer qualify for SSI due to the cost-of-living increases in excess of current income standards.

Pickle Cases. Individuals who receive Social Security, lost their SSI since April 1977 for any reason, and would be eligible if the cost of living adjustment were disregarded.

Disabled Adult Children. Individuals over age 21 who receive Social Security benefits from a parent and who lost their eligibility as a SSI recipient when they became eligible for disability or the cost of living increase caused them to lose SSI.

Widows/Widowers. This includes Disabled Widow(er)s who lost SSI due to the elimination of the actuarial reduction factor and those at age 60 who lost SSI due to Title II retirement entitlement or who became eligible for Title II due to the change in SSA disability criteria for widow(er)s effective January 1, 1001, and who do not have Medicare coverage.

Qualified Disabled Working Individuals (QDWI). Disabled working individuals under age 65 who are entitled to Medicare Part A. The state pays the Medicare Part A premium for those who meet the criteria. They are not eligible for TennCare unless they meet the requirements of another category.

Qualified Medicare Beneficiary (QMB). Coverage provides Medicaid coverage of Medicare covered services by paying the Medicare premium, coinsurance and deductibles of eligible individuals. The individual must be eligible for Medicare Part A and meet income and resource standards.

Special Low Income Medicare Beneficiary (SLMB). Coverage pays Medicare Part B premiums only for individuals whose income is equal to or less than 120% of the poverty level and who meet resource requirements.

Qualifying Individuals (QI). Coverage pays the Medicare Part B premium on a "first come, first serve" basis if all requirements for SLMB are met except that income is greater than 120% of the poverty level and does not exceed 135% of the poverty level.

Cluster-Daniels Lawsuit Individuals. Individuals must have received a minimum of one SSI check in Tennessee since November 1987 and have had their SSI terminated while a resident of Tennessee.

Title IV-E Children. Children for whom adoption assistance or foster care assistance payments are made as authorized under Title IV-E of the Social Security Act are eligible for Medicaid.

Medically Needy

Groups that are classified as Medically Needy must meet technical eligibility criteria like that applied to Categorically Eligible groups, but the financial criteria in the amount of the resources and income limits is different. For those who have income over the established Medically Needy Income Standard, (MNIS), children and pregnant women with countable income greater than the income limits may be eligible for Medicaid if they have incurred medical expenses at least equal to the difference between their income and the income limit. This is the Spend-down provision.

Medical Assistance for Children. Children who are under the age of 21 who meet technical and financial requirements. The caretaker is eligible if pregnant or under 21.

Pregnant Women. Pregnant women who meet the technical and financial requirements during their pregnancy are eligible.

Children in Special Living Arrangements. Children under age 21 who are in foster homes or private institutions and DHS is making some payment for their care, or are receiving active treatment as inpatients in an accredited psychiatric facility or program, or are in an adoptive home through an adoption subsidized in part or in full by a public agency may receive Medicaid benefits.

Effective close of business on April 29, 2005, only children and pregnant women may be considered for Medically Needy either as applicants or for review for an additional period of eligibility.

Existing Medically Needy Adults

Although non pregnant adults may no longer qualify as Medically Needy due to closed enrollment, those adults who were currently eligible and had a future end date as a Medically Needy Adult in June of 2005 have been allowed to remain eligible for Medicaid as Medically Needy for now. These adults include those who are aged, blind, disabled or the caretaker of a child under 21. This also includes Medically Needy Institutionalized individuals whose income is over the Medicaid Income Cap, but who are exceptionally eligible in a Long Term Care Facility. These individuals will remain eligible as Medically Needy until given an opportunity to qualify based on new guidelines, as yet undetermined.

Tenncare Standard

Effective close of business on April 29, 2005, no new applicants are eligible for TennCare Standard (TCS). Children under age 19 who were receiving TCS benefits at the close of business on April 29, 2005 will continue to receive coverage until a change is reported that makes them ineligible or until reverification for this group begins in 2006 and they are determined ineligible (whichever occurs first).

Children who are under age 19 and are no longer eligible in a Medicaid category will still be considered for TCS coverage. To be eligible for TCS, the family's income must be less than 200% of the Federal Poverty Level (FPL), and the parent(s) cannot have health insurance or access to group health insurance for the children.

If the income of the budget group is more than 200% of the FPL, and there is no health insurance or access to group health insurance coverage for the children, the children will be considered for Medically Eligible (ME) coverage.

GUIDE

The TennCare Medicaid and TennCare Standard Policy Manual combines Volume I, Institutionalized Individuals; Volume II, Family and Children's Medicaid; the TennCare Handbook; and the revised bulletins and memorandums not included in these manuals into one volume. As policy and procedures change, manual revisions will be made appropriately as promptly as possible.

The Table of Contents provides hyperlinks to topics throughout the Manual which may be accessed by a left click of the computer mouse. The following clarifications should assist in reading this material:

The Medicaid program is referred to as "TennCare Medicaid" in most instances. The TennCare waiver program is referred to as "TennCare Standard".

Applicants and recipients of benefits are referred to as "clients" as consistently as possible. However, the term "client" is used interchangeably with "customer," "participant," "applicant/recipient," or "individual."

The term "aid group" refers to a group of individuals who are eligible and receiving benefits in a category of assistance. This term may be used interchangeably with "assistance group". However, the term "budget group" refers to those individuals whose income, resources, and needs are required by policy to be considered in determining eligibility. Consequently, the budget group may contain individuals who are not included in the aid or assistance group.

The state employee who determines eligibility for assistance is referred to as the "DHS caseworker". However, the term "case manager" or "eligibility counselor" may be used interchangeably.

The Department of Human Services is referred to as "DHS" or "the department" interchangeably. The same is true for the Bureau of TennCare which may also be referred to as the "TennCare Bureau".

TENNCARE MEDICAID RULES INDEX

Legal Base or State Rule	Topic
42 CFR 435.919	Advance notification
1996 Federal Welfare Reforms, Section 1931 of the Social Security Act	AFDC-Medicaid Only
42 CFR 435:520 State Rule: 1240-3-2-.03 (3) (a)	Age Requirements
42 CFR 435.608	Application for Other Program Benefits
42 CFR 435.610 State Rule: 1240-3-3-.02(8)	Assignment of Third Party Medical Support
42 CFR 435:409, 435:408 State Rule: 1240-3-02 (5)	Citizenship Requirement
42 CFR 431.300 ff Subpart F	Confidentiality Standards
PL 99-643, Section 6	Disabled Adult Children
OBRA, Section 9116, PL 100-203	Disabled Widows/Widowers Part II
OBEA 1990, Section 5103	Disabled Widows/Widowers Part III
42 CFR 435.913	Documentation
42 CFR 435/910 State Rule: 1240-3-3-02 (10)	Enumeration Requirements
42 CFR 435.602 1240-1-4-.17-(7) (b)	Financially Responsible Relatives
42 CFR 435-132	Grandfathered-In SSI eligibles
20 CFR 416.1103	Income
42 CFR 435.1008 and 1009 PL 97-35, Section 2176 of the Omnibus Budget Reconciliation Act of 1988	Institutional status
42 CFR 435.300 1240-3-2-.03	Medically Needy Assistance for Pregnant Women/Children under 21
42 CFR 435.912	Negative case actions
42 CFR 431.52	Out-of State Services
Sixth Omnibus Budget Reconciliation Act of 1986	Poverty Level Income Standard eligibility
Section 1920 of the Social Security Act	Presumptive eligibility for pregnant women
42 CFR 435:403	Prohibition Against Concurrent Receipt of Benefits
OBRA, Sections 6012 & 6048(d)	Qualified Disabled Working Individuals
PL 100-360, Section 301	Qualified Medicare Beneficiaries
42 CFR 435.403 State Rule: 1240-3-.02 (6)	Residency Requirements
1240-3-2-.02	Sibling Income/Medicaid Only

Social Security Act—Section 1902 & 1905	Specified Low Income Medicare Beneficiaries
PL 94-566, Section 503	SSI Pass Along/Pickle eligibility
42 CFR 233.106 1240-1-3-.60	Striker Policy
Section 1115 waiver for Medicaid	TennCare Standard
PL 106-354 2(b) (1)	Women Diagnosed with Breast/Cervical Cancer
1200-13-14-.02-(1)	Delineation of Agency Roles and Responsibilities
1200-13-14-.02-(2)	Technical and Financial Eligibility Requirements for TennCare Standard
1200-13-14-.02-(3)	Covered Groups Under TennCare Standard During Periods of Closed Eligibility
1200-13-14-.02-(4)	Covered Groups Under TennCare Standard During Periods of Open Eligibility
1200-13-14-.02-(5)	Loss of Eligibility
1200-13-14-.02-(6)	TennCare Partners Program
1200-13-14-.02-(7)	Processing of New Applications for TennCare Standard During the Wavier Transition Period From the Former Waiver to the New Waiver During the Period From July 1, 2002 to December 31, 2002
1200-13-14-.02-(8)	Renewal of TennCare Standard Eligibility after December 31, 2002
1200-13-14-.02-(9)	Disenrollment Related to TennCare Standard Eligibility Reforms
1200-13-14-.02-(10)	Delineation of TennCare Standard Enrollee's Responsibilities
1200-13-14-.03	Enrollment, Disenrollment, Re-enrollment and reassignment
1200-13-14-.04	Covered Services
1200-13-14-.05	Enrollee Cost Sharing
1200-13-14-.06	Managed Care Organizations
1200-13-14-.07	Managed Care Organizations Payment
1200-13-14-.08	Providers
1200-13-14-.09	Third Party Resources
1200-13-14-.10	Exclusions
1200-13-14-.12	Other Appeals By TennCare Applicants and Enrollees
1240-13-14-.13	Members Abuse and Overutilization of the TennCare Program
1200-13-14-.14	Repealed

DEFINITIONS

1931 Coverage — AFDC-MO (section 1931) - Refers to Section 1931 of the Social Security Act which requires that any family group that applies for cash assistance but fails due to regulations applicable to Families First (TANF) must be tested for eligibility under the pre-TANF regulations in effect prior to July 16, 1996.

2350 — A long term care facility or HCBS agency reports the admission and discharge of its TennCare Medicaid eligible patients and applicants, including SSI recipients, in writing via this form titled "Notice Recipient-Patient Was Admitted To or Discharged From Skilled Nursing Home Care or Intermediate Care" to DHS.

2362 — A form used to manually update or correct Bureau of TennCare files regarding patient liability in a long term care facility. There are limitations on when this form can be used.

Accommodations — DHS is required to provide reasonable accommodations to applicants/recipients to ensure that they have equal access to benefits and services which includes, but is not limited to, modifying existing facilities to make them accessible, acquiring or modifying equipment, and providing readers or sign language interpreters.

Adult — For TennCare Medicaid, over the age of 21. For TennCare Standard, over the age of 19.

AFDC — Aid to Families with Dependent Children is the name of the cash assistance program for dependent children and their caretakers now known as Families First. Families First was established in July 1996 as a waiver of the federal Temporary Aid for Needy Families or TANF program obtained by Tennessee.

Alerts — The database generates worker notifications based on conditions in a case such as age change, incapacity review, etc. called alerts.

Annuity — A type of trust with periodic payments generated by a bank or insurance company from funds deposited by the individual either in a lump sum or installments to establish a source of income for a future period.

Appeal — An applicant or recipient of TennCare Medicaid or TennCare Standard may disagree with the state's decision on their case to the county, state, or district DHS office and ask for a fair hearing.

Behavioral Health Organization	The TennCare Partners Program is to provide mental health and substance abuse services to all TennCare Enrollees and certain non-TennCare individuals. The TennCare Partners Program is delivered through BHOs operating under contract to TDMHDD.
Black Lung	Refers to benefits received by an individual who was a coal miner and who is totally disabled due to pneumoconiosis, or the dependent spouse, surviving or divorced spouse or the child (under 18) of an eligible miner.
Budgeting	Determining income eligibility which requires defining the budget group individuals, applying appropriate income exclusions or disregards, and comparing the gross countable income to the income standard for that category and the budget group size.
Burial Reserve	Burial arrangements, cash, accounts, or other financial instruments which are clearly designated for burial expenses.
Categorically Needy	Categorically Needy individuals are entitled to the broadest scope of Medical Assistance benefits. All recipients of cash assistance under the Families First program for families and the SSI program for the Aged, Blind or Disabled are Categorically Needy. In addition, many adults, families, pregnant women and children who do not receive cash assistance receive the Categorically Needy level of benefits for Medicaid Only assistance.
Changes	Refers to changes which occur in an assistance group between regular case reviews that affect the assistance group's eligibility, such as, obtaining employment.
Child	For TennCare Medicaid, birth to age 21. For TennCare Standard, birth to age 19.
Cluster-Daniels Case	Refers to a lawsuit filed in November 1987 which has prohibited the termination of TennCare Medicaid coverage for SSI cash recipients whose cash assistance has ended.
Community Spouse	Term used to refer to the spouse of an institutionalized individual who remains at home.
Confinement	Admission to an institution to live or enrollment in a HCBS project to receive treatment or services as required.
Continuous Confinement	An individual has been confined to a medical institution or a series of medical institutions

	(including services in a hospital, nursing facility, intermediate care facility, or intermediate care facility for persons with mental retardation) and /or has been enrolled in an HCBS waiver program or any combination thereof that is continuously received for 30 consecutive days or for individuals enrolled in a Home and Community Based Services (HCBS) waiver program, the individual has to be determined to need and to be likely to receive services for a continuous period of at least 30 days going forward.
Cooperation with Child Support	As a condition of TennCare Medicaid eligibility, the parent or caretaker relative of a child receiving benefits must give information about the absent parent(s) of the children and cooperate with the IVD Agency as necessary to obtain medical support for the children.
Covered Services	Refers to the benefits paid by the Bureau of TennCare for eligible individuals. Coverage is similar but not entirely the same for TennCare Medicaid and TennCare Standard recipients.
Disabled Adult Children	Extends TennCare Medicaid benefits to individuals who would be eligible for SSI but for entitlement to or increase in the amount of the DAC Social Security benefits.
Disability Determination Services	Makes disability determinations for the Social Security Administration's SSI and Social Security disability benefits. In the past also made disability determinations for adult Medically Needy benefits.
Deemed Income	Income considered available to any member of a budget group from a financially responsible relative.
Dependent Allocation	Income allotted from the eligible individual to all persons who can be or are being claimed as tax dependents and includes adult dependent children, parents and/or siblings as well as minor children.
Disability	An individual is considered to be disabled if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to last for a continuous period of not less than 12 months.
Discrimination	Refers to treating an individual differently due to age, race, color, sex, disability, religious creed, national origin, or political belief.
Disenrollment	Refers to the action to terminate TennCare coverage for currently eligible TennCare Standard adults, age 19 and over as of 8-31-05.

Earned Income	Compensation an individual receives for the performance of services as a result of his own efforts either as an employee or through self-employment.
Emancipated	A child under age 21 who is considered legally liberated or is legally liberated from parental control or responsibility.
Emergency Alien Eligibility	Undocumented aliens (and newly lawful aliens) who are aged, blind, disabled or Cuban/Haitian entrants, or under age 18 may be eligible for only emergency Medicaid services when all eligibility requirements other than citizenship and enumeration are met.
Enrollment	Refers to the process by which individuals are assigned eligibility for TennCare benefits. Enrollment usually refers to TennCare Standard enrollees.
Enumeration	Individual has a valid Social Security account number and can provide documentation to DHS.
Excess Shelter Allowance	An allowance from the patient liability amount for a participant in a LTCF or HCBS for the spouse at home when total shelter costs for rent, mortgage, taxes and insurance, any maintenance charges, or utility costs exceed the Standard Maintenance Amount (SMA). Refer to SMA definition.
Exceptionally needy	In Medically Needy budgeting, if the income is equal to or less than the MN income standard, the budget group is "exceptionally eligible" and will receive continuous TennCare Medicaid coverage.
Ex-parte	Case review without the client present for an interview.
Extended Medicaid	Medicaid coverage is available for 12 months if the AG is closed due to receipt or increase in child support or spousal support. The AG must have been eligible three out of the six months prior to the month of ineligibility.
Fair Hearing	After receiving an appeal, DHS Division of Appeals and Hearings will determine if a fair hearing is granted based on a valid factual dispute.
Family Assistance Service Centers	A call center staffed by DHS caseworkers who answer program and case specific inquiries, make case changes, reschedule appointments and file appeals.
Families First	Tennessee's TANF program (Temporary Assistance for Needy Families, formerly known as Aid to Families with Dependent

	Children [AFDC]) which provides cash assistance to dependent needy children and their caretakers. TennCare Medicaid is automatically provided with FF assistance.
Financially Responsible Relative	The income and resources of a legally married spouse and a legal parent for a child are considered in the budgeting process for eligibility.
Good Cause	Situation where the participant has a valid reason for not participating in a program requirement. Specifics vary per eligibility criteria.
Hardship	When the individual or his/her spouse has no resources in excess of the resource limit, is otherwise eligible, and for whom the loss of TennCare Medicaid would result in the loss of essential nursing care not available from any other source.
Health Insurance Portability and Accountability Act	Protects the confidentiality of medical records and health information and sets rules which govern the use and disclosure of private health information.
Home and Community Based Services	A waiver of the TennCare Medicaid statutory requirement in which services are provided to individuals in their own homes who would otherwise require long term nursing home care.
Homestead	A home and the surrounding land to which the client has the intention to return or which is the principal place of residence for the client and/or his/her spouse.
Hospital application	Application for assistance accepted and processed by DHS caseworkers who are out-stationed at a hospital or medical facility.
I-94 Card	One means of verifying the legal status of an alien.
Incapacity	A physical or mental defect, illness, or impairment. Supported by competent medical testimony and of such a debilitating nature as to reduce substantially or eliminate the individual's ability to support or care for children.
INFOPAC	Computer database of reports developed for use in assisting with case maintenance.
In-kind Wages	The value of food, clothing, shelter or other items provided to the client by his employer instead of or in addition to cash.
Inmate	An individual living in a public institution with some exceptions and always any person who was committed to the penal system with no

	exceptions.
Institution	An establishment that provides food, shelter, treatment and/or services to four or more individuals.
Institutionalized Individual	Aged, blind or disabled individual currently confined for at least 30 consecutive days to a medical institution (including services in a hospital, nursing facility, intermediate care facility, or intermediate care facility for persons with mental retardation) and/or enrolled in a HCBS program or any combination thereof that has been continuously received for at least 30 consecutive days if he is not an inmate or in a mental institution; or for individuals applying to enroll in a Home and Community Based Services (HCBS) waiver program, the individual has been determined to need and to be likely to receive services for a continuous period of at least 30 days going forward.
Interview	Opportunity for caseworker and client to communicate so that information is collected to determine eligibility for TennCare Medicaid or other Family Assistance programs.
In-Kind Support and Maintenance	Considered as unearned income in the determination of eligibility for the SSI-related categories of TennCare Medicaid.
Item D	Deduction from the patient liability amount for expenses incurred by eligible individuals in a LTCF for medical or remedial care that are recognized by state law as medical and/or remedial care items but are not included in the state's TennCare Medicaid plan.
Limited English Proficiency	DHS must take steps to ensure that LEP persons who apply for or receive TennCare Medicaid have meaningful access to those programs; the most important step is providing language assistance at no cost to the LEP person.
Liquid Assets	Cash or other assets the individual has on hand and owns jointly or individually that could be converted to cash and used for support/maintenance.
Living Arrangements	Individual's status as an at-home or institutionalized individual and whether he was admitted voluntarily or involuntarily.
Long Term Care Facility	More commonly referred to as a nursing home. Care can be skilled or intermediate in level. Participants must be confined to an approved ward. Also known as a Title XIX medical institution.
Lump Sum	One-time payment usually for retroactive benefits, such as Social Security.

MA J	ACCENT category which designates the participants as eligible in either a Certain Child of a Specified Age or Pregnant Woman PLIS category.
Major Parent	Term used to refer to the parent of a minor parent.
MA S	ACCENT category which designates the Categorically Eligible program that provides medical assistance to families with dependent deprived children and their needy caretaker relatives who are ineligible for the Families First cash assistance program solely because of income from a sibling, including half and step siblings.
MA T	The database category which designates the Medically Needy program for which TennCare Medicaid benefits are available to the child who meets all requirements and is under age 21 or a pregnant adult.
MA X	The database category which designates a TennCare Standard case.
MA Z	The database category which designates Medical Assistance for Women Diagnosed with Breast/Cervical Cancer
Managed Care Organization	TennCare services are offered through several managed care entities. Each enrollee has a Managed Care Organization (MCO) for his primary care and medical/surgical services.
Medicaid Extend	TennCare coverage extended beyond the eligibility end date to allow for further processing.
Medicaid Rollover	An individual, under age 19, losing TennCare Medicaid has an opportunity to apply for enrollment in TennCare Standard.
Medical Institution	Authorized by state law and organized to provide medical care including nursing and convalescent care.
Medically Eligible	Those who have medical problems that prevent them from getting health insurance.
Medically Needy	Those individuals whose income or resources disqualify them for Categorically Needy coverage may qualify for Medically Needy benefits if their income and resources fall within the Medically Needy criteria or their medical expenses exceed the excess amount of income. In Tennessee, only pregnant adults and children under 21 are considered for Medically Needy eligibility.

Medicare	The national health insurance program for people age 65 or older, some people under age 65 with disabilities, or people with End-Stage Renal Disease (ESRD), which is permanent kidney failure requiring dialysis or a kidney transplant.
Medical Evaluation Unit	Qualified medical staff housed in the DHS state office who make decisions concerning the medical/mental incapacity of adults for Families First.
Non-liquid Assets	Resources which are not immediately convertible to cash.
Old Age, Survivors, and Disability Insurance	Social Security Administration benefits.
Overpayments	An individual is authorized for benefits during a period when he is not eligible to receive benefits. This may be due to a client error or failure to report information or due to a DHS error.
Personal Needs Allowance (PNA)	Deduction from the institutionalized individual's patient liability amount to cover personal needs and incidentals. Currently the amount is $40 per month. For HCBS, 200% of the SSI-FBR, and 300% of the SSI-FBR for individuals enrolled in the MR Self Determination waiver program.
Poverty Level Income Standard	Assistance groups whose gross income does not exceed various percentages of the Federal Poverty Level Income Standard.
Pre-Admission Evaluation	An approved PAE is required prior to vendor payments being made in a long term care facility or HCBS. This is the responsibility of the Bureau of TennCare.
Presumptive eligibility	Temporary TennCare Medicaid coverage authorized by a qualified medical provider and available to pregnant women and women with cervical or breast cancer.
Provider	An organization or company that provides access to a service or system, in this case, a health care provider.
Public Assistance Reporting Information System	A voluntary information exchange system between states designed to identify individuals who may be receiving benefits or have unreported income in more than one state.
Public Institution	Serving more than 16 residents that is the responsibility of or controlled by a government unit.
Quality Control	A system designed to reduce erroneous expenditures by monitoring

	eligibility determination, third party liability activities, and claims processing
Qualified Medicare Beneficiary	Coverage provides Medicaid coverage of Medicare covered services by paying the Medicare premium, coinsurance, and deductibles of eligible individuals. The individual must be eligible for Medicare Part A and meet income and resource standards.
Qualified Disabled Working Individuals	Provides for certain disabled working individuals under age 65 who have exhausted their Medicare coverage an option to purchase Medicare Part A for an indefinite period.
Qualifying Individuals	Coverage pays the Medicare Part B premium on a "first come, first serve" basis if all requirements for SLMB are met except that income is greater than 120% of the poverty level and does not exceed 135% of the poverty level.
Real Property	Any buildings and/or land, improved or unimproved, including burial plots, recreational, residential, or commercial property, and the value of a mobile home.
Reapplication	When the individual submits a written request to apply within 90 days of the date of his/her most recent denial (rejection) of an application for benefits or closure of his/her active TennCare Medicaid case.
Redetermination	Subsequent eligibility determination on an active case at 12 months. Also called a review.
Refugee	Individuals from any country who have fled or cannot return to their country of nationality because of persecution or fear of persecution on account of race, religion, or political opinion and who have been granted parole status in the U.S. and individuals granted asylum (not applicants for asylum).
Relationship	In order for the caretaker relative who is pregnant or under age 21 to receive assistance, the child in his/her care must be living in the home of a parent or certain relative who is within the 5th degree of relationship to the child.
Renewal	The process of determining continuing eligibility for individuals who receive TennCare Standard.
Residence, principal place of	Current residence at which the individual intends to reside permanently or for an indefinite period.
Resources	Cash or other liquid assets or any real or personal property than an

	individual owns jointly or individually that could be converted to cash and used for support and/or maintenance.
Reverification	Refer to the definition for "renewal". Reverification is a different term for the same process.
Review	Refer to the definition for "redetermination". Review is a different term for the same process.
Railroad Retirement Benefits	The individual, or his/her financially responsible relative worked for the railroad, or a company closely associated with the railroad, is at least age 60 or disabled or the dependent of a railroad worker.
Special Low Income Medicare Beneficiary	Coverage pays Medicare Part B premiums only for individuals whose income is equal to or less than 120% of the poverty level and who meet resource requirements.
Standard Maintenance Amount	Amount of income allocation to the spouse at home which is based on 150% of the PLIS for 2 persons divided by 12 months.
State Online Query	Is a method of verifying Title II (RSDI) and Title XVI (SSI) benefits for applicants and recipients of public assistance. When a request is keyed by a caseworker, it is immediately transmitted via a telephone line to the Social Security Administration (SSA), and the response is returned immediately.
Spend Down	Medically Needy coverage for pregnant adults and children to age 21 with net income greater than the income standard when the amount of their excess income on a monthly basis is exceeded by medical expenses.
Spousal allocation	Refers to the income deducted from the eligible institutionalized individual's patient liability to meet the needs of a spouse who remains at home.
Spousal impoverishment	Term introduced by the Medicare Catastrophic Coverage Act of 1988 that provides a more liberal treatment of the income and resources of the institutionalized individual who has a legal spouse living at home.
Supplemental Security Income	A Federal income supplement program funded by general tax revenues (not Social Security taxes) and is designed to help aged, blind and disabled people who have little or no income.
SSI Pass Along/Pickle	Coverage group for individuals who received Social Security benefits and SSI during the same month, but who no longer qualify for SSI due to the cost-of-living increase in excess of current income

	standards. Those who meet these criteria and lost their SSI since April 1977 for any reason and would be eligible if the cost of living adjustment were disregarded are "Pickle" cases.
SSI Terminations	Cluster-Daniels Lawsuit Individuals who are those individuals that remain eligible for TennCare Medicaid because they received a minimum of one SSI check in Tennessee since November 1987 and had their SSI terminated while a resident of Tennessee.
SSI-FBR	Refers to the income standard used to determine eligibility for the SSI program. FBR = Federal Benefit Rate.
Striker	Individual participating in any strike or other concerted stoppage of work by employees.
Temporary Assistance for Needy Families	Program which was created by the Welfare Reform Law of 1996. TANF became effective July 1, 1997, and replaced what was then commonly known as welfare: Aid to Families with Dependent Children (AFDC.) TANF in Tennessee operates under a waiver and is called Families First.
Temporary Absence	An absence from the home of the eligible individual that is of short duration with specific intentions of returning on or about a specific date.
TennCare Bureau (or Bureau of TennCare)	The 'Single State Agency" in Tennessee. The Bureau of TennCare contracts with DHS to perform eligibility for TennCare Medicaid and TennCare Standard.
Third Party Medical Support	Any payments made by an entity that is not the client and not the State including a responsible relative or an insurance company.
Title IV-E	Coverage group for children whom adoption assistance or foster care assistance payments are made authorized under Title IV-E of the Social Security Act and are eligible for Medicaid. This group is NOT discussed in this Manual.
Title XIX	The Social Security Act created for the purpose of enabling each State, as far as practicable under the conditions, to furnish medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals whose income and resources are insufficient to meet the costs of necessary medical services. The sums made available under this section are used for making payments to States with State plans for medical assistance which have been submitted and are approved by the Secretary of Health and Human Services.

Transfer of Assets	Giving away or conveying an asset (other than excluded assets) for less than fair market value within the past 36 months (beginning 8-11-93) of an application as an institutionalized individual. (Note: There is a 30 month look back period for transfers occurring prior to 8-11-93.)
Transferring Cases	Movement of an active case on the DHS database from one county office to another. In some cases, pending applications may be transferred.
Transitional Medicaid	Medicaid coverage is available for 12 months if the AG is closed for earnings or increased work hours. The AG must have been eligible three out of the six months prior to the month of ineligibility and all other requirements should be met.
Trickling	Term used to refer to the process in ACCENT whereby the system considers eligibility for all aid groups in all available categories of assistance. At the AEIAG screen, ACCENT calculates and re-groups as needed to offer aid group choices to the DHS caseworker.
TWISS Form	The case data form used to authorize assistance prior to ACCENT and still used to authorize refugee assistance and alien emergency medical services.
Underpayments	A mistake made by the DHS caseworker, e.g., an arithmetical mistake or failure to act promptly regarding a reported change that resulted in an overstated liability.
Underwriter	An insurance company employee who can identify and calculate the risk of loss from policyholders, establish appropriate premium rates, and write policies that cover these risks.
Unemployment	Compensation that provides workers, whose jobs have been terminated through no fault of their own, monetary payments for a given period of time or until they find a new job.
Unearned Income	Money an individual receives that is not the result of his current work efforts but accrues to him as the result of investment, inheritance, or previous work efforts.
Veterans Administration	Refers to the income provided to a veteran, the child or spouse of a disabled or deceased service person or veteran, the unmarried widow/widower of a deceased service person or veteran, and/or the parent of a service person who died before January 1, 1997 from a service connected cause.

Vendor Payments	Benefits paid to cover cost of care for eligible institutionalized individuals.
Verification	The evidence that proves something is true and correct.
Voter Registration	The National Voter Registration Act, popularly known as Motor Voter reduces necessary and burdensome bureaucratic obstacles to voter registration. The law requires states to provide uniform registration services through drivers' license agencies, through public assistance and disability agencies and through mail-in registration
Widows/Widowers	Disabled widows/widowers (w/w) who received SSI benefits prior to age 60 and received a spouse's Title II retirement benefit upon reaching age 60 and lost SSI eligibility because of that benefit will be deemed eligible for SSI from age 60 until age 65 if they are not eligible for Medicare Part A benefits and remain SSI eligible on all other eligibility areas.
Workman's Compensation	Benefits paid to a permanently or temporarily disabled worker by his/her employer or the employer's insurance company.

TECHNICAL ELIGIBILITY REQUIREMENTS

The Technical Eligibility Requirements chapter outlines the policies and procedures for these eligibility requirements:

- Age
- Unborn status
- Enumeration
- Striker policy
- Living arrangements

AGE

Policy Statement

Legal Base: 42 C.F.R. 435:520
State Rule 1240-3-2.03(3)(a)

In order to be eligible for TennCare Medicaid benefits, a child for purposes of TennCare Medicaid categories must be under age 21. In order to eligible for TennCare Medicaid benefits as aged, an individual must have attained age 65. (Assistance based on attaining the age of 65 is limited to eligibility as residents of Long Term Care Facilities or Home and Community Based Services.)

Verification of Age

Proof of age is required if the individual applies on the basis of his/her age. Verification of the individual's age becomes a permanent part of the case record.

The following is a list of evidence acceptable for age verification.

- Baptismal Certificate
- Birth Certificate
- Birth Verification
- Census Bureau Records
- Delayed Birth Certificate
- Family Bible
- Hospital Records
- Immigration Record
- Insurance Policy
- Military Record
- Passport
- Proof of entitlement to Social Security benefits based on age under Title II and/or Title XVIII of the Act.
- School Records
- Tennessee Clearinghouse System can provide birth verifications for most Tennessee births after 1914.

Case Record Documentation

Document the electronic case record concerning any documents or other forms of verification used to establish birth. Record all document numbers.

The data base will send an Alert to the DHS caseworker when a child's age should be reviewed.

UNBORN STATUS

Policy Statement

The unborn child is considered an individual and, if a member of a Budget Group (BG), is accorded all the consideration due BG members, i.e., the unborn's needs are considered in determining financial eligibility if the pregnancy is verified. When it is medically verified that there is more than one fetus, include the needs of the unborn(s) in the BG.

An unborn child(ren) is/are not an individual(s) for Aid Group membership; therefore, unborn children are not eligible to receive TennCare Medicaid benefits. The newborn child(ren) is/are eligible for benefits in the newborn category to age one from the date of birth and as long as the mother was TennCare Medicaid eligible at the time of the birth and if the newborn(s) continue(s) to live with her.

The newborn whose mother was not eligible for TennCare Medicaid or who does not continue to live with her may, upon its birth, be eligible for TennCare Medicaid benefits, if he/she meets the technical and financial criteria of any other TennCare Medicaid category.

Pregnancy Verification

Written medical verification of pregnancy is required. Acceptable pregnancy verification has the following characteristics:

- Prepared and signed by medical personnel including but not limited to a physician, nurse, health clinic, paraprofessional, etc., and
- The written verification bears a current date and includes at least an estimated date of delivery, if not a date of conception.

ENUMERATION REQUIREMENT

Policy Statement

Legal Base: 42 C.F.R. 435.910
State Rule 1240-3-3-.02(10)

As a condition of eligibility to receive TennCare Medicaid, each applicant/recipient included in the aid group must:

- Have a valid social security account number and/or claim number and provide documentation of such to the Department; or

- If any individual's account number is unknown or if a number has never been issued, apply for a number prior to approval.

Explanation of the Enumeration Requirement to the Applicant/Recipient

Advise each applicant or recipient of the regulation requiring that individuals furnish a social security number to DHS and how it is to be used. Include the information below:

- You are only required to furnish a social security number for the individuals in your household who are applying for the program benefits.
- This is a requirement of the State and Federal government.
- Failure to furnish a social security number or proof that you have applied can result in that individual's ineligibility.
- The social security number will only be used to determine eligibility for benefits.
- Unless there is a name change you will only have to furnish your social security number one time.

Verification Procedures

Individual with Social Security Number

- When the caseworker has viewed an individual's Social Security card or has validated the SSN on State Online Query (SOLQ) and evidence of the individual's identity is documented in the electronic case record, the SSN on the individual's social security card or validated on SOLQ will be considered a verified social security number, and it will be entered on the system.

- Once a social security number has been verified, and the client's identity is not questionable, do not re-verify.

Individual without a Social Security Card

- The applicant/recipient must furnish SSN or apply for one prior to approval.

- If at application, the applicant reports not having the SSN or if the SSN is questionable, he or she can apply for an SSN at the DHS county office.

- Form SS-5 which is provided by the Social Security Administration is kept in the DHS county office to be used to apply for an SSN.

- The worker is required to complete the SS-5, review it with the applicant for correctness, and obtain the applicant's signature on the form prior to him/her leaving the office.

- The worker must document the verification of identity, age, and citizenship or alien status for the SS-5 as required by the SSA.

- If the HH/AG member has reached his/her 18th birthday and never applied for an SSN, an in-person interview is mandatory.

Special Situations

- A newborn can be added to its mother's case without having to wait for the enumeration process to conclude. In most situations, the enumeration process (completion of SS-5) now occurs for newborns at the hospital.

- It is not a condition of eligibility for refugees to be enumerated for purposes of assistance through the Refugee Assistance Program. However, most refugees are issued a Social Security Number at the Resettlement Centers.

- Special provisions are available for enumerating elderly persons (such as nursing home recipients) who have no birth records.

- The newborn must be enumerated by age one, or before he/she can be approved in any other TennCare Medicaid category (whichever occurs first).

Recording and Documentation

The electronic case file must include documentation that:

- The enumeration requirement has been discussed; and

- Each individual in the household that is applying for benefits has or has applied for a valid Social Security Number; including the date applied, and

- How age, citizenship and identity for each aid group member was established.

- The electronic case record should contain all recorded document numbers and the date they were viewed.

Enumeration for Legal Aliens

As a condition of eligibility to receive TennCare Medicaid, applicants must either have or have applied for a Social Security number. Documented aliens who need to be enumerated in order to be eligible for our benefit programs may need our assistance in securing non-work Social Security numbers. SSA policy permits the issuance of Social Security

numbers for people who do not have work authorization when a Social Security number is required to obtain benefits. To obtain this non-work Social Security number, an applicant must provide:

- Evidence of age;
- Identity
- Alien status, and
- Documentation from the appropriate government entity explaining the need for the Social Security number.

DHS is committed to assisting applicants in securing the documentation necessary for an application to be processed. Therefore, DHS county offices must provide an original letter to SSA on DHS letterhead stationery explaining why a non-work Social Security number is required.

STRIKER POLICY

Policy Statement

Legal Base: 45 C.F.R. 233.106
State Rule 1240-1-3-.60

Individuals who do not qualify for Families First solely due to a parent being on strike, may be Medicaid eligible only if all other eligibility requirements are met for one of the following categorically needy coverage groups:

- MA P for pregnant women in first two trimesters with no other child(ren)
- MA J for pregnant women and children
- MA K for pickle/passalongs, widow(er)s, disabled adult children
- Transitional Medicaid

Individuals who are ineligible for Families First solely due to a parent being on strike may not be Medically Needy eligible (i.e. MA T exceptional or spend down categories). This means a caretaker or child can only qualify if included in the Transitional Medicaid, poverty level (PLIS) categories, or as a SSI Pass Along/Pickle case.

If individuals are ineligible for Families First due to income and/or resources, they may be TennCare Medicaid eligible as categorical or medically needy in any of the above named categories.

Caretakers other than parents who are on strike do not affect TennCare Medicaid eligibility of a child under age 21. The caretaker other than a parent who is not eligible for Families

First solely due to a strike, may qualify for TennCare Medicaid under categorically needy coverage groups only as indicated above.

Definitions of Terms in this Part

Strike	The term "strike" includes any strike or other concerted stoppage of work by employees including a stoppage by reason of expiration of a collective bargaining agreement, any concerted slowdown, or other concerted interruption of operations by employees.
Participating in a Strike	The term "participating in a strike" means an actual refusal, in concert with others, to provide services to one's employer(s). If the client reports his/her participation in a strike, document the case with his/her statement and add any substantiating evidence he/she provided.

LIVING ARRANGEMENTS

The following types of living arrangements preclude the individual's eligibility for TennCare Medicaid or to be included as a member of a budget group:

Confinement as an Inmate in a Public Institution

The individual placed by a court order as an inmate in a public institution is not eligible for TennCare Medicaid benefits. A public institution is one that provides shelter, food and treatment or services to at least four persons and which is the responsibility of or controlled by a governmental unit. For purposes of this section, public educational or vocational schools are not "public institutions".

Private Unlicensed Institutions

The individual confined to a private institution that has not been licensed by the Department of Health and certified to provide the type of care the individual requires is not eligible for TennCare Medicaid. A private institution is one under private administrative control or management that provides shelter, custodial care, personal services and some nursing care to at least two persons and is funded entirely by private funds or a combination of private and public funds.

Non-Patient Status in a Medical Institution

An individual confined to a medical institution for purposes of shelter or custodial care because of a disability for which he does not receive continuing planned medical treatment

and which makes him unable to maintain himself outside the institution, is not a patient of the institution and is therefore ineligible for TennCare Medicaid benefits. A medical institution is one established to provide medical care including nursing and convalescent care and employs the necessary professional personnel, equipment and facilities to manage its patients' medical needs on a continuing basis.

Psychiatric Facility

An individual under age 21 who is an inmate of a psychiatric facility is not eligible for TennCare Medicaid. Verification of the child's status is determined by receipt of Form HS-2137, Patient Referral/Discharge Notification for Under 21 Medicaid Benefits, from the psychiatric facility. Receipt of this form certifies that the child meets the eligibility requirements regarding voluntary admission.

Correctional/Detention Facilities

The individual confined to a detention facility or classified as "delinquent" in a public facility serving more than 16 persons is ineligible for TennCare Medicaid benefits. A delinquent is a minor child adjudicated as "delinquent" in the court order for placement and who is also confined to a public facility.

Other Juveniles

The individual confined to another type of institution such as a maternity home, nursing home, or convalescent care center is not eligible for TennCare Medicaid benefits unless:

- His confinement is temporary, i.e., less than 3 months duration; or
- is confinement is expected to continue for 30 days or less and his prospective living arrangement is a qualifying one and he is otherwise eligible.

For example, a child confined to a maternity home on June 29 is expected to be released in 18 days and to return to live with her mother. The child may be TennCare Medicaid eligible as early as July 1.

THE RESIDENCY REQUIREMENT

Legal Base 42 C.F.R. 435.403
State Rule 1240-3.02 (6)

Policy Statement

TennCare Medicaid benefits are available to eligible residents of the State of Tennessee, including (under certain conditions) residents who are absent from the State.

Principal Place of Residence

(TCA-71-5-120 STATE RULE – 12-10-3-3-(.02)(1)(6)

For purposes of TennCare Medicaid eligibility, the principal residence is defined as the current residence at which the individual intends to reside permanently, or for an indefinite period. The TennCare Reform Act of 2002 requires an applicant to declare "under penalty of perjury" that the adult applicant does not own or lease a "principal residence" outside of this state.

EXCEPTION: Individuals who are confined to a LTCF with the intent to return to their principal place of residency may be outside of the state.

The determination of an individual's state of residence involves the analysis of several factors including the individual's age, capability, intent, and the degree of a state's involvement in the institutional placement of the individual. Additional provisions include:

- There is no durational state residency requirement.
- There is no pre-institutionalization state residency requirement.
- There is no fixed address requirement for the non-institutionalized.

The individual determined to be a resident of another state that has declined or not yet signed an Interstate Reciprocal Agreement with Tennessee is not eligible for TennCare Medicaid benefits. (More information concerning Interstate Reciprocal Agreements is included later in this Chapter.)

If a determination is made that an individual is not a Tennessee resident and therefore not eligible, this must be thoroughly documented in the electronic case record system. This is particularly important if the individual owns or leases a principal residence in another state.

Age in Determining Residency

Individual under age 21

- Emancipated

  For the individual who is emancipated from his parent, OR legally married AND capable of expressing intent, the state of residence is the state where the individual lives with the intention to remain there permanently or for an indefinite period. The individual must not have been placed in an institution by another state.

- Unemancipated

For the individual who is unmarried, not emancipated from parental control, or became incapable of expressing intent prior to attainment of age 21, the state of residence may be either that of his parents, legal guardian or the filing party, dependent on the following variables:

- If parental rights remain intact, the individual's state of residence is that of the parent at either the time of placement in the institution or the time the application is filed by the parents.

- If parental rights have been terminated, the individual's state of residence is that of the legal guardian at the time of the placement in the institution or the time the application is filed by the legal guardian.

- If the individual is abandoned by his parents and has no legal guardian, the state of residence is that of the party who files the application in his behalf.

- The child in a Title IV-E adoption or foster care placement is a resident of the state where the child actually resides regardless of the state which has responsibility for the IV-E case.

Individual age 21 and Over

The concept of "**capability**" is central to this section. For an individual who became incapable at age 21 or later, the state of residence is the state in which the individual is physically present UNLESS he was placed in the institution by another state.

The state of residence for the individual who is capable of expressing his intent is the state where the individual is living with the intention to remain permanently or for an indefinite period UNLESS the individual has been placed in the institution by another state.

Capability in Determining Residency

The evaluation of an individual's capability to indicate his intent is central to the determination of state residency. Absent any evidence to the contrary, as stipulated below, the client is considered capable of indicating his intent.

An individual is considered to be incapable of expressing his intent under the following conditions:

- Diminished mental capacity. Tests indicate the individual has an I.Q. of 49 or less OR a mental age of 7 or less.

- Legal Judgment of Incompetency. The individual has been judged incompetent by a court.

- Medical Documentation of Incompetency. A statement from the attending physician or psychologist that the individual is incapable, OR a statement from another person licensed by the State in the field of mental retardation.

NOTE: The SSA's determination that the individual requires a representative payee is not sufficient documentation of incapability but is supporting evidence.

Use the following methods to gather sufficient evidence to determine capability:

- Obtain test results/summaries which include specific findings, such as I.Q. and/or mental age.
- Obtain a copy of the court record indicating adjudication.
- Obtain a statement from the attending physician or psychologist regarding the applicant/recipient's capability.
- Caseworker observations (if any) regarding the client's degree of capability.
- Statements of the responsible party and/or the party filing in the client's behalf concerning the individual's degree of capability.

Intent in Determining Residency

The capable individual must indicate his intention to remain in the state permanently or for an indefinite period. Evidence of intent includes:

- Admission to a long term care facility,
- Identifiable living arrangement established prior to institutionalization.

  NOTE: This is not a requirement to establish state residency but is supporting evidence.

- Job commitment or/job search prior to institutionalization.
- The individual's statement of his intent.

State Placement

Any institutionalized individual placed in Tennessee by another state is considered to be a resident of the state responsible for placement. Any institutionalized individual in another state placed there by the State of Tennessee is considered to be a Tennessee resident.

Any agency of the state government OR any entity recognized under state law as being under contract with the state that arranges for an individual to be placed in an institution located in another state is considered to be acting on behalf of the state in making the placement.

NOTE: "Entity" includes private agencies and agencies of the Federal government.

"Placement" is considered as any action beyond providing information to the individual and/or his family. Giving basic information about another state's Medicaid program and the availability of health care services and facilities in another state is considered placement.

Initiation of transfer, admission or placement of an individual in another state due to lack of sufficient and/or appropriate facilities constitutes a placement by the initiating state.

Reimbursement of transportation expenses attendant to a transfer or move to another state is considered a placement by the state paying the transportation expenses.

"Interruption of the Placement" occurs once a competent individual leaves the facility in which he was placed by the state. Upon interruption, the individual's state of residence is the state in which he is physically located provided he intends to remain there as specified.

State Supplemental Payments

The state of residence for an individual receiving a State Supplementary Payment (SSP) is the state paying the SSP. Interstate Reciprocal Agreements (applies to Institutionalized Individuals Only).

An individual determined to be a resident of another state may be eligible for benefits in Tennessee IF:

- The state in which he/she has residency has signed an interstate agreement with Tennessee; and
- He/she is eligible in all other respects.
- For those who satisfy the residency requirement on the basis of an interstate agreement, residency is considered to be effective the later of:
- The date of arrival in Tennessee; or
- The effective date of the Interstate Agreement.

Interstate Agreements in effect

State	Agreement Effective Date
Alabama	July 1, 1981
Arkansas	October 1, 1981
California	August 1, 1981
Florida	July 1, 1981
Georgia	December 1, 1980
Idaho	September 1, 1981
Iowa	August 1, 1981
Kansas	September 1, 1981
Kentucky	October 1, 1981
Louisiana	November 30, 1981
Maine	August 1, 1981
Maryland	December 15, 1985
Minnesota	September 1, 1981
Mississippi	July 1, 1981
New Jersey	September 1, 1981
New Mexico	September 1, 1981
North Dakota	August 1, 1981
Ohio	November 1, 1981
Pennsylvania	February 1, 1982
South Dakota	October 1, 1981
Texas	October 1, 1981
West Virginia	August 1, 1981
Wisconsin	April 6, 1982

States that refuse an Intestate Agreement

The following states have declined to sign an Interstate Reciprocal Agreement with Tennessee:

- Alaska
- District of Columbia
- Indiana
- Michigan
- Nebraska
- Oklahoma
- South Carolina
- Virginia
- Washington

An individual determined to be a resident of another state with which Tennessee does not have a reciprocal agreement is not eligible in the State because he/she fails to meet the residency agreement.

Temporary Absence From Tennessee

A temporary absence from the state does not preclude continued eligibility when:

- The absence is for a specific purpose such as a temporary work assignment, visit, hospitalization, participation in an educational or rehabilitation program not available in Tennessee; or
- For children in treatment centers for sex offenders or alcohol and drug abuse, the treatment can be in-state or out-of-state; AND
- The individual indicates his intent to return to Tennessee once the purpose for his absence is accomplished.

During a temporary absence:

- Obtain the client's anticipated date of return.
- Follow up with the client within 5 working days of the anticipated date of return.
- If a review is required during the period of absence, follow review procedures and secure assistance from the other state if necessary.
- If, at any time during the absence, it is determined that the individual is no longer eligible for benefits for any reason, take steps to close the case.

NOTE: Application and/or receipt of public assistance benefits including Medicaid in another state indicates intent to reside elsewhere and results in the loss of Tennessee residency.

CITIZENSHIP

Policy Statement

Legal Base: 42 C.F.R. 435:409, 435:408
State Rule: 1240-3-.02(5)

Effective 7/1/06, the Deficit Reduction Act (DRA) amends federal Medicaid law to require **all** citizens applying for or renewing their Medicaid coverage to provide satisfactory documentary evidence of citizenship or nationality. This requirement applies to all applicants and recipients of Medicaid, TennCare Standard, and any other 1115 medical assistance waiver program. The citizenship documentation requirement does not change Medicaid rules relating to immigrants. Undocumented immigrants remain eligible only for emergency Medicaid services.

NOTE: Individuals who are not able to document citizenship may receive Families First (FF) cash but will not be eligible to receive the companion Medicaid coverage. This will require a fiat to remove the individual from the Medicaid assistance group.

The DRA of 2005 has very specific requirements for documentary evidence and the federal government has adopted a hierarchical approach in the way verification **must** be obtained. There are four levels of **acceptable documentary evidence** that must be used to satisfy the citizenship requirement and states must begin with acceptable primary evidence. If the primary source of evidence is not available, then states must use evidence from the secondary level and if that is not available, then move to the third level of acceptable evidence. As a last resort, the fourth level of acceptable evidence may then be used.

Documents obtained from the primary list are the most reliable primary documentary evidence and may be used to verify citizenship and identity. If the individual is not able to produce an item that is an acceptable primary source of evidence, the state may then try to obtain evidence from the acceptable evidence identified as secondary through fourth levels of evidence. Secondary through level four sources of evidence may be used to verify citizenship only and the individual will be required to also present an acceptable form of identity.

Section 1903(x) of the Social Security Act (the Act), which establishes new requirements for documentation of citizenship by Medicaid applicants or recipients who declare they are citizens or nationals of the United States.

Section 1903(x)(2) has been amended to exempt two additional groups of individuals from the provisions requiring presentation of satisfactory documentary evidence of citizenship or nationality. The two groups are:

- Individuals receiving Social Security Disability or Supplemental Security Income (SSI) based on the individual's disability; and

- Individuals to whom child welfare services are made available based on the child being in foster care, or receiving adoption assistance or foster care assistance.

An individual is a citizen of the United States if:

- He/she was born in the United States, District of Columbia, Puerto Rico, Guam, Virgin Islands or the Northern Mariana Islands, or

- He/she is a naturalized citizen, or

- He/she was born abroad to U.S. citizens, or

- He/she is a national from American Samoa or Swain's Island, or

- He/she was born abroad and adopted by a U.S. citizen in accordance with the Child Citizenship Ac of 2000, when:
    - at least one parent of the child is a U.S. citizen, either by birth or naturalization;

- the child is under age 18;
- the child is residing in the United States in the legal and physical custody of the U.S. citizen parent after having been lawfully admitted into the country as an immigrant for lawful permanent residence; and
- the adoption is final.

The citizenship requirement applies to all Medicaid applicants and recipients. New applicants must provide satisfactory evidence effective July 1, 2006 and recipients already enrolled in Medicaid will be required to document their citizenship at the time of their re-determination review. Documentation of citizenship is a one-time requirement. The four levels of acceptable citizenship documentation and the acceptable identity documentation follows:

Primary Documentation to Verify Citizenship and Identity

Primary evidence of citizenship and identity is documentary evidence of the highest reliability. Applicants or recipients born outside of the U.S. must submit a document listed under primary evidence of U.S. citizenship.

Primary Documents	Explanation
U.S. passport	The Department of State issues this. A U. S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation.
Certificate of Naturalization (N-550 or N-570)	Department of Homeland Security issues for naturalization.
Certificate of Citizenship (N-560 or N-561)	Department of Homeland Security issues Certificate of Citizenship to individuals who derive citizenship through a parent.

Secondary Documents to Establish U.S. Citizenship

Secondary evidence of citizenship is only used when primary evidence of citizenship is not available and only after a "Reasonable Opportunity Period" has been given. (Reasonable Opportunity is defined below). **The documents listed below must be originals or copies certified by the issuing agency**. Copies or notarized copies may not be accepted.

If the individual was born in Tennessee after 1949, the birth record should be available on Tennessee Clearinghouse. This is an acceptable secondary source and if Tennessee Clearinghouse is used, the case record must be thoroughly documented.

• A U.S. public birth record showing birth in • One of the 50 U.S. states • District of Columbia • American Samoa • Swain's Island • Puerto Rico (if born after January 13, 1941) • Virgin Islands of the U.S. (on or after January, 17,1917) • Northern Mariana Islands (after November 4, 1986 (NMI local time) or • Guam (on or after April 10, 1899)	The State, Commonwealth, territory or local jurisdiction may issue the birth record document. It must have been issued before the person was 5 years of age. An amended birth record document that is amended after 5 years of age is considered fourth level evidence of citizenship. **Note:** If the document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana Island before these areas became part of the U.S., the individual may be a collectively naturalized citizen. Collective naturalization occurred on certain dates listed for each of the territories. See additional Requirement below for Collective Naturalization).
Certification of Report of Birth (DS-1350)	The Department of State issues a DS-1350 to U.S. citizens in the U.S. who were born outside of the U.S. and acquired U.S. citizenship at birth, based on the information shown on the FS-240. When the birth was recorded as a Consular Report of Birth (FS-240), certified copies of the Certification of Report of Birth Abroad (DS-1350) can be issued by the Department of State in Washington, D.C. The DS-1350 contains the same information as that on the current version of Consular Report of Birth FS-240. The DS-1350 is not issued outside the U.S.
Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240)	The Department of State consular office prepares and issues this. A Consular Report of Birth can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside of the U.S. to U.S. military personnel usually have one of these.
Certification of Birth Abroad (FS-545)	Before November 1, 1990, Department of State consulates also issued Form FS-545 along with the prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form FS-545. Treat an FS-545 the same as the DS—1350.

United States Citizen Identification Card (I-197) or the prior version I-179 (Section 6036 referred to these documents in error as an I-97).	INS issued the I-179 from 1960 until 1973. It revised the form and renumbered it as Form I-197. INS issued I-197 from 1973 until April 7, 1983. INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings Although neither form is currently issued, either form that was previously issued is still valid.
Final adoption decree for children born in the U.S.	The adoption decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized and the State in which the child was born will not release a birth certificate prior to final adoption, a statement from a State approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.
Children born outside the U.S. and adopted by U.S. citizen	In order to qualify for Medicaid, the child must meet the following: At least one parent of the child is a U.S. citizen, either by birth or naturalization. The child is under the age of 18. The child must be residing in the U.S. in the legal custody of the U.S. citizen parent after having been lawfully admitted into this country as an immigrant for lawful permanent residence. If the child has been adopted, the adoption must be final. To meet citizenship requirement for Medicaid eligibility, the four (4) requirements listed above must be met and DHS must view the final adoption decree.
Evidence of civil service employment by the U.S. government	The document must show employment by the U.S. government before June 1, 1976

Official Military record of service	The document must show a U.S. place of birth (for example DD-214 or similar document showing a U.S. place of birth).
American Indian Card (I-872)	DHS issues this card to identify a member of the Texas Band of Kickapoos living near the U.S. /Mexican border. A classification code "KIC" and a statement on the back denote U.S. citizenship.
Northern Mariana Card (I-873)	The former Immigration and Naturalization Service (INS) issued the I-873 to collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986. The card is no longer issued, but those previously issued are still valid.

Third Level Documents to Establish U.S. Citizenship

Third level of evidence of U.S. citizenship is used when neither primary nor secondary verification is obtained within the "Reasonable Opportunity Period". A second document will be needed to verify identity.

Extract of hospital record on hospital letterhead established at the time of the person's birth and was created at least 5 years before the initial application date and indicates a U.S. place of birth	Do not accept a souvenir "birth certificate" issued by the hospital. Note: For children under 16 the document must have been created near the time of birth or 5 years before the date of application.
Life or health or other insurance records showing U.S. place of birth and was created at least 5 years before the initial application date.	Life or health insurance records may show biographical information for person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.

Fourth Level Documents to Establish U.S. Citizenship

Fourth level of evidence is the least reliable and should only be used in the rarest of circumstances. Only accept this form of evidence if the applicant alleges U.S citizenship and there is nothing indicating he/she is not a citizen and a document verifying identity is presented.

Federal or State census record showing U.S. citizenship or U.S. place of birth (Generally for persons born 1900 through 1950	The census record must also show the applicant's age. **Note:** Census records from 1900 through 1950 contain certain citizenship information. To secure

	this information the applicant, recipient or State should complete a form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U. S. citizenship data requested". Also add that the purpose is for Medicaid eligibility. This form requires a fee.
Other document as listed in the explanation that was created at least 5 years before the application for Medicaid.	This document must be one of the following and show a U.S. place of birth: Seneca Indian tribal census record. Bureau of Indian Affairs tribal census records of the Navaho Indians. U.S. State Vital Statistics official Notification of birth registration. An amended U.S. public birth record that is amended more than 5 years after the person's birth. Statement signed by the physician or midwife who was in attendance at the time of birth.
Institutional admission papers from a nursing home, skilled nursing care facility or other institution and was created at least 5 years before the initial application date and indicates a U.S. place of birth	Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.
Medical (clinic, doctor, or hospital) record and was created at least 5 years before the initial application date and indicates a U.S. place of birth	Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S, citizenship when it shows a U.S. place of birth. Note: An immunization record is not considered a medical record for purposes of establishing U.S. citizenship. Note: For children under 16 the document must have been crated near the time of birth or 5 years before the date of application.
Written Affidavit (notarized statements)	Affidavits should ONLY be used in rare circumstances. An affidavit by at least two individuals of whom one is not related to the applicant/recipient and who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship. The person(s) making the affidavit must be able to

	provide proof of his/her own citizenship and identity for the affidavit to be accepted. If the affiant has information which explains why documentary evidence establishing the applicants claim of citizenship does not exist or cannot be readily obtained, the affidavit should contain this information as well. It must also be signed under penalty of perjury by the person making the affidavit. A second affidavit from the applicant/recipient or knowledgeable individual explaining why documentary evidence does not exist or cannot be readily obtained must also be requested.

Evidence of Identity

Identity must also be established. When primary evidence of citizenship is not available, a document from lists 2 through 4 may be presented if accompanied by an identity document from this list.

Certificate of Degree of Indian or Indian Blood, or other U.S. American Indian/Alaska Native tribal document.	Acceptable if the document carries a photograph of the applicant or recipient, or has other personal identifying information relating to the individual.
Any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act	Use 8 CFR 274a.2 (b) (1) (v) (B) (1). This section includes the following acceptable documents for Medicaid purposes: Driver's license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex race, height, and weight or eye color. School identification card with a photograph of the individual. U. S. military card or draft record. Identification card issued by the Federal, State, or local government with the same information included on drivers licenses. Military dependent's identification card. Native American Tribal document. U. S. Coast Guard Merchant Mariner card.

Acceptable Documentation for Children Age 16 or Younger to Verify Identity

- School identification card with photograph.
- Military dependent's identification card if it contains a photograph.
- School record that shows date and place of birth and parent(s) name.
- Clinic, doctor or hospital record showing date of birth.
- Affidavit signed under penalty of perjury by a parent or guardian attesting to the child's identity.

NOTE: For children under 16, school records may include nursery or daycare records. If none of the above documents in the preceding charts are available, an affidavit is acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided. An affidavit can not be used to verify identity if one was used to verify citizenship.

Collective Naturalization

The following will establish U.S. citizenship for collectively naturalized individuals:

Puerto Rico

Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on January 13, 1941; or

Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.

U.S. Virgin Islands

Evidence of birth in the U.S. Virgin Islands, and the applicant's statement of residence in the U.S., a possession, or the U.S. Virgin Island on February 25, 1927;

The applicant's statement indicating residence in the U.S. Virgin Island as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession, or the U.S. Virgin Island on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; or

Evidence of birth in U.S. Virgin Islands and the applicant's statement indicating residence in the U.S., a U.S. possession or territory or the Canal Zone on June 28, 1932.

Northern Marina Islands (NMI) (formerly part of the Trust Territory of the Pacific Island (TTPI)

Evidence of birth in the NMI, TTPI citizenship, and residence in the NMI, the U.S. or a U.S. territory or possession on November 3, 1986 NMI local time and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986.

Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1986 (NMI local time) , voter registration prior to January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).

Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).

NOTE: If a person entered the NMI as a non-immigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not an U.S. citizen.

Treatment of Titled IV-E Children and Individuals Receiving Services through Medicaid Section 115 Demonstration

Title IV-E children receiving Medicaid must have in their Medicaid file a declaration of citizenship or satisfactory immigration status and documentary evidence of the citizenship or satisfactory immigration status claimed on the declaration. (IV-E children's eligibility will be determined by the Department of Children Services).

Individuals who apply or who are receiving benefits under a Section 1115 Demonstration Waiver (such as TennCare Standard) are also subject to the citizenship and identity requirements.

Reasonable Opportunity for New Applicants

Effective July 1, 2006, new applicants will be given a "Reasonable Opportunity Period" to present documents establishing citizenship or nationality. A reasonable opportunity for new applicants cannot exceed the federal requirements for timeliness (45/90 days). The timeliness provision assures that applicants are given reasonable opportunity to present documents without delaying eligibility or the fair hearing process. You may accept verification of citizenship or identity without requiring the applicant to appear in person however you must require individuals who are applying to provide you with acceptable verification of citizenship and identity. Applicants may not be determined eligible for Medicaid until they have provided the required verifications.

Reasonable Opportunity for Active Recipients

As re-determination reviews come due on or after July 1, 2006, active recipients will be given "Reasonable Opportunity" to provide verification of citizenship and identity. If good faith has been demonstrated, active recipients will remain eligible until the next review appointment.

Good Faith

An example of Good Faith Effort is when the applicant or recipient has written emailed or faxed Vital Records in his/her state of birth and is waiting to receive a certified copy of the birth certificate. Proof of the effort must be provided to the DHS eligibility counselor at the time of re-determination.

If born in Tennessee, the birth record can be obtained via Tennessee Clearinghouse or the individual may apply for a birth certificate at his/her local Department of Health office. If the individual was born in the U.S. but not within the state of Tennessee, the DHS counselor will assist by providing the Vital Records' address in the individual's state of birth.

Vital Records' addresses may be obtained by accessing www.vitalrec.com. This website is the "most comprehensive resource for locating vital records on the internet". After it has been determined by the DHS counselor and the DHS supervisor that the applicant/recipient has been given a "Reasonable Opportunity Period" to provide necessary evidence and it has not been provided, a decision to deny benefits to a new applicant and/or terminate eligibility for an active recipient may be made.

Case Record Documentation

Citizenship has to be verified only once. We do not retain copies, but rather document in the electronic record the documents that were provided by the client to establish citizenship and identity. In addition to entering the correct code in the verification field, the running record should be thoroughly documented. For example, documentation using a birth certificate should include:

- The state where the birth certificate was issued
- Birth Certificate number
- Individual's complete name at birth
- Date of birth
- City or county of birth
- Parent(s) name
- Documentation of whether original or certified copy of birth certificate was seen.

Eligible Aliens

In order to be eligible for TennCare Medicaid coverage, an individual must be a citizen of the United States, a naturalized citizen, certain American Indians born outside the United States or a qualified alien.

Qualified Aliens

The following are considered qualified aliens:

- An individual may be eligible for TennCare Medicaid if the individual is residing in the U.S. with the knowledge and permission of the Immigration and Naturalization Services (INS) and the INS does not contemplate enforcing the alien's departure.
- Aliens who are permanently residing in the U.S. under the color of law or as listed below.
- Aliens admitted to the U.S. pursuant to 8 U.S.C. 1153 (a) (7) (section 203 (a) (7) of the Immigration and Nationality Act).
- Aliens, including Cuban/Haitian entrants, paroled in the U. S. pursuant to 8 U.S.C. 1182 (d) (5) (section 212(d) (5) of the Immigration and Nationality Act).
- Aliens residing in the U. S. pursuant to an indefinite stay of deportation.
- Aliens residing in the U.S. pursuant to an indefinite voluntary departure.
- Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition who are entitled to voluntary departure (under 8 C.F.R. 242.5 (s) (2) (vi)) and whose departure INS does not contemplate enforcing.
- Aliens who have filed applications for adjustment of status pursuant to section 245 of the Immigration and Nationality Act (8 U.S.C. 1255) that the INS has accepted as "properly filed" within the meaning of 8 C. F. R. 245.2 (a) (1) or (2) and whose departure the INS does not contemplate enforcing.
- Aliens granted stay of deportation by court order, statue or regulation, or by individual determination of the INS pursuant to section 106 of the Immigration and Nationality Act (8 U.S.C. 1105a) or relevant INS instructions, whose departure the agency does not contemplate enforcing.
- Aliens granted asylum pursuant to section 208 of the Immigration and Nationality Act (8 U.S.C. 1157).
- Aliens admitted as refugees pursuant to section 207 of the Immigration and Nationality Act (8 U.S.C. 1157).
- Aliens admitted as Afghan Immigrants pursuant to section 525 of Title V described in Section 101(a)(27) of the Immigration and Nationality Act (INA).
- Aliens admitted as Iraqi Immigrants pursuant to section 1244 of Public law 110-181, National Defense Authorization Act.
- Aliens granted voluntary departure pursuant to section 242 (b) of the Immigration and Nationality Act (8 U.S.C. 1252 (b)) whose departure INS does not contemplate enforcing.

- Aliens granted deferred action status pursuant to Immigration and Naturalization Service Operations Instruction 103.1 (a) (ii) prior to June 15, 1984 or section 212.1 (22) issued June 15, 1984 or later.
- Aliens residing in the United States under orders of supervision pursuant to section 242 of the Immigration and Naturalization Act 8 U.S.C. 1252 (d).
- Aliens who have entered and continuously resided in the United States before January 1, 1972 (or any date established by section 249 of the Immigration and Naturalization Act, 8 U.S.C. 1259).
- Aliens granted suspension of deportation pursuant to section 244 of the Immigration and Naturalization Service does not contemplate deportation of Aliens whose deportation has been withheld pursuant to 243 (h) of the Immigration and Nationality Act (8 U.S.C. (h)).
- Any other aliens living in the United States with the knowledge and permission of the Immigration and Naturalization service whose departure that agency does not contemplate enforcing.

Victims of Trafficking

The Trafficking Victims Protection Act of 2000 (TVPA) allows victims of human trafficking, to receive federally funded benefits and services to the same extent as refugees. Victims of human trafficking are non-citizens who are eligible to receive a special visa and benefits once they are identified.

Assistance Available to Victims of Human-Trafficking

Adult victims of human trafficking who are certified by the U.S. Department of Health and Human Services (HHS) who are otherwise eligible may receive Medicaid in any Medicaid category available including Refugee Medicaid. Children under age 18 do not have to be certified by HHS to receive benefits. For an adult victim of trafficking to receive certification, he/she must:

- Be a victim of human trafficking as defined by TVPA
- Be willing to assist with the investigation and prosecution of traffickers; and
- Have completed a bona fide application for a T Visa or,
- Have received continued presence status from the U.S. Department of Homeland Security.

The T Visa - Under the (TVPA) of 2000

The T Visa was established to allow victims of severe forms of trafficking to become temporary residents of the U.S. The Act recognizes that returning victims to their country of origin is of ten not in the best interest of victims and those victims need the opportunity to rebuild their lives without the threat of deportation. A recipient of a T Visa, after three years, may be eligible for permanent residence status if he/she meets the following conditions:

- They are a person of good moral character.

- They have complied with any reasonable request for assistance in the investigation during the three-year period
- They will suffer extreme hardship if they are removed from this country.

The Certification Process

The Certification Process typically takes only a few days after HHS is notified that a person has made a bona fide T Visa application or has been granted continued presence status (both of these actions are completed by the U.S. Department of Homeland Security). If the status of a person who has received HHS certification changes so that they are no longer eligible, HHS may be required to decertify that individual.

How can a Victim's Certification be Verified?

You may call a toll-free number for victims of trafficking 1-866-401-5510. Before victims can receive benefits, the eligibility counselor must call the toll-free trafficking victim verification line to verify the validity of the certification letter and to also inform HHS that the individual has applied for program benefits.

Child Victims off Human-Trafficking- Prior to the enactment of the TVPA in October 2000

No comprehensive federal law existed to protect victims of trafficking or to prosecute their traffickers. The TVPA of 2000, 2003 and 2005 is intended to prevent human trafficking overseas, to increase prosecution of human traffickers, to protect victims and to provide federally funded or administered benefits and services so that qualified victims can safely rebuild their lives in the United States. Children as well as adult victims may be eligible for the T Visa, which allows victims of trafficking to remain in the U.S. and become eligible for work authorization. Un accompanied trafficked children are also eligible for a range of services and places them in culturally appropriate foster homes, group homes, or independent living arrangements, appropriate to their developmental needs.

If you believe you have come in contact with a victim of human trafficking, call the National Human Trafficking Resource Center at 1-888-37737.888. For more information on human trafficking, visit www.acf.hhs.gov/trafficking.

Limited Eligibility for Qualified Aliens

Qualified Alien Status, in and of itself is not sufficient to establish eligibility for TennCare Medicaid. Aliens who entered the U.S. on or after August 22, 1996 have a 5-year bar before potential eligibility for TennCare Medicaid.

EXCEPTION: The 5-year limitation on eligibility to Lawfully Admitted Permanent Resident (LAPR) aliens does not apply if the LAPR alien:

- Entered the U.S. before August 22, 1996 and obtained qualified alien status before August 22, 1996.

- LAPR with 40 qualifying quarters of earnings. **NOTE**: There is a 5-year bar to eligibility for individuals who entered the U.S. on August 22, 1996 or later (unless certain exemptions apply).
- Veteran or active duty member of the U.S. Armed Forces, a spouse of a veteran, or a dependent child of a veteran/active duty member.
- Lawfully residing in the U.S. on August 22, 1996 and is blind or disabled.
- Entered the U.S. as a refugee under section 243 (h) of the INA as in effect prior to April 1, 1997 or withholding or removal under section 241 (b) (3) of the INA.
- Was granted asylum under section 208 of the INA.
- Was granted withholding of deportation under section 243 (h) of the INA as in effect prior to April 1, 1997 or withholding or removal under section 241 (b) (3) of the INA.
- Was granted Cuban and Haitian entrant status under section 501 (e) of the Refugee Assistance Act of 1980.
- Was admitted to the U.S. as an Amerasian Immigrant pursuant to section 584 of the Foreign Operation, Export Financing, and Related Programs Appropriations Act of 1988.
- Is an American Indian born in Canada under section 289 of the INA or a member of a federally recognized Indian Tribe as defined in section 4 (e) of the Indian Self-Determination and Education Assistance Act.
- Aliens admitted as an Afghan Immigrant under section 525 of Title V resettlement Special Immigrant status described in Section 101(a)(27) of the Immigration and Nationality Act (INA) resettlement assistance entitlement programs, are eligible to receive public benefits to the same extent as refugees for **six months** after their date of entry into the United States, or from the date he or she is granted Special Immigrant status. Benefits cannot be authorized prior to December 26, 2007. At the end of their six months eligibility period**, Afghan Special Immigrants and their families may only qualify for Emergency Medicaid services, until such time that they satisfy the 5-year bar applicable to most qualified aliens.**
- Iraqi aliens who have been granted Special Immigrant status described in section 101(a)(27) of the Immigration and Nationality Act (INA) resettlement assistance entitlement programs, are eligible to receive public benefits to the same extent as refugees for **eight months** after their date of entry into the United States, or from the date he or she is granted Special Immigrant status. Benefits cannot be authorized prior to December 26, 2007. At the end of their eight- month eligibility period, **Iraqi Special Immigrants and their families may only qualify for Emergency Medicaid services, until such time that they satisfy the 5-year bar applicable to most qualified aliens.**

Aliens: Permanently Residing Under Color of Law (PRUCOL) and Aliens Granted: "Indefinite Voluntary Departure"

These are aliens living in the U. S. with the knowledge and permission of INS and whom INS does not plan to deport. Aliens in a lawful status include:

- Asylees granted asylum in U.S. for political or religious reasons pursuant to §208 of INA.

- Aliens admitted as "conditional entrant's" or refugees under 207 of the Refugee Act of 1980 (P.L. 96-212) or as refugees under §203 (a)(7) of the INA.

- Cuban/Haitian entrants admitted as refugees for humanitarian reasons under section §212 (d) (5) of the INA. (See the Refugee Resettlement Program chapter in this Manual regarding eligibility for this group of aliens and refugees if they are not eligible for Families First or regular TennCare Medicaid benefits.)

- Aliens residing in the U. S. under an "Order of Supervision" who have been found deportable except for age, physical condition, humanitarian concerns or other reasons which make it unlikely that the alien will be deported.

- Aliens residing in the U. S. on an indefinite voluntary departure; or granted voluntary departure pursuant to §242(b) of INA; or granted suspension of deportation pursuant to §244 of INA; or aliens residing in the U. S. on an indefinite stay of deportation, or aliens whose deportation has been withheld pursuant to §243(h) of the INA.

- Aliens for whom a petition of voluntary departure has been granted to an immediate family member which covers the family and whose departure INS does not plan to enforce (e.g. immediate relative of an American citizen and a Form I-130 has been filed for the alien.)

- Aliens who have filed an application for adjustment of status under §245 INA.

- Aliens who have continuously resided in the U. S. since before January 1, 1972 and are presumed by INS to meet criteria for lawful permanent residence. Documentary proof establishing entry and continuous residence is required.

- Aliens living in the U. S. with the knowledge and permission of INS, and INS does not contemplate enforcement of departure.

- PRUCOL aliens may be eligible for full TennCare Medicaid coverage if all eligibility requirements are met (Note: Certain refugees may be eligible for Refugee Resettlement Program assistance if entry in the U. S. was within the past 12 months), and the applicant has INS documentation with an expiration date of one

year from the date of issuance which is an indication that INS does not contemplate enforcing the individual's departure. If the applicant presents an expired document or one with an expiration date of less than one year from the date of issuance, this is an indication that INS may be contemplating departure. An exception to this assumption is if the alien presents a letter from INS showing the alien is being allowed to remain in the U. S. for a specified period of time due to conditions in the alien's home country (extended voluntary departure).

PRUCOL aliens applying for TennCare Medicaid must sign the Application for Assistance (HS-0169). Adults must sign for children under age 18. The primary and/or secondary verification procedures outlined in the Verification of Alien Status section below must be followed. The following documents when confirmed through primary and/or secondary verification procedures as outlined in the Verification of Alien Status section below will verify PRUCOL status:

- Form I-94 with one of the following legends:
    - "Refugee Conditional Entry"
    - Parole pursuant to 212 (s)(5)
    - Asylee pursuant to 208 (or other pertinent section)
    - "Admitted as a refugee pursuant to 207 of the INA"
    - "Cuban/Haitian Entrant (Status Pending) Reviewable January 15, 1981"
    - May have passport stamped "adjustment application" or "employment authorization during status as adjustment application".
- Form I-94 with no legend accompanied by an INS letter regarding INDEFINITE:
    - Stay of deportation
    - Voluntary departure
    - Stay of deportation OR
    - Immediate relative petition approved
    - Suspension of deportation pursuant to 244 of the INA
    - Deportation withheld (should also have an order from an immigration judge).
- Form I-220B
- Form I-210
- Form I-181
- I-151 or I-551
- Order from Immigration regarding deportation withheld 243(h)

- INS letter used in lieu of or in conjunction with other INS forms to identify alien status.

NOTE: Cuban/Haitian entrants, refugees and individuals granted indefinite asylum may qualify for assistance under the Refugee Resettlement Program if not otherwise eligible for Families First and/or TennCare Medicaid. See that chapter in this Manual for information.

American Indian Born in Canada

An Indian born in Canada who is at least one-half American Indian blood may enter and reside lawfully in the U. S. This does not extend to the spouse or child of the Indian unless they are at least one-half American Indian also. An Indian meeting the above criteria may be eligible for full TennCare Medicaid coverage if all eligibility requirements are met. The following documents may be used to verify the Indian is at least one-half American Indian blood:

- Birth or baptismal certificate issued on reservation
- Tribal record
- Letter from the Canadian Department of Indian Affairs
- School records

Ineligible Aliens

These aliens may be lawfully admitted for a temporary or specified period of time. They include foreign students, visitors, foreign government representatives on official business, crewmen on shore leave, treaty traders and investors and families, temporary workers including agricultural contract workers and members of the foreign press, radio, film and other media.

These aliens are not eligible for full TennCare Medicaid benefits because of the temporary nature of their admission status. They, however, may be eligible for emergency services only, as outlined in this section if residency requirements are met. Ineligible aliens may have one of the following types of documentation:

- Form I-94, Arrival/Departure Record
- Form I-185, Canadian Border Crossing Card
- Form I-186, Mexican Border Crossing Card
- Form SW-434, Mexican Border Visitor's Permit
- Form I-95A, Crewman's Landing Permit

Seven (7) Year Time Limit

A TennCare Medicaid LAPR may continue to eligible if all financial and technical requirements are met for 7 years. In order to continue to be eligible after the expiration of

the 7-year limit, the LAPR must have attained citizenship status or he/she loses eligibility effective with the first month beginning after the 7th anniversary date of:

- Admission as a refugee, or
- Withholding of deportation or removal, or
- Being granted asylum, or
- Becoming a Cuban/Haitian entrant,
- Being granted Amerasian immigrant status.

An alien in one of the time-limited categories can remain eligible beyond the 7-year period if at the time of filing or at any time during or after the 7-year period, the INS determines that the alien continues to be a Qualified Alien and that he/she is one of the following:

- Lawfully residing in the U.S. and was receiving TennCare Medicaid benefits on August 22, 1996, OR
- Blind or disabled and was lawfully residing in the U.S. on August 22, 1996
- LAPR with 40 qualifying quarters (QQ)
- A veteran, or an active duty member of the Armed Forces of the U.S., or a spouse of a veteran or active duty military personnel, or a child of a veteran or person in active duty in the U.S. armed forces.

EXAMPLE: Helene Betan entered the U.S. on June 27, 1999 from Cuba. She filed for asylum on that date. Helene is not aged or disabled. Her eligibility is based on time-limited eligibility as a Cuban/Haitian entrant. Helene applies for Medicaid on March 2, 2004 as aged because she attained the age of 65 on February 4, 2004.

Helene's 7-year time limit count began from the date she entered the U.S. as an asylee. She is potentially eligible beginning April 2, 2004 until July 1, 2006.

NOTE: Entering the correct date of entry for the LAPR will enable the data base to correctly determine the 7-year time period.

Verification of Alien Status

Verification of alien status must be presented by the applicant prior to approval. If an alien is unable to provide a document that will verify alien status, the caseworker has no responsibility to contact the Bureau of Citizenship and Immigration Services (BCIS) on the alien's behalf.

When a person indicates inability or unwillingness to provide documentation of alien status, that person should be classified as an ineligible alien. The caseworker's responsibility exists only when the alien has a BCIS document that does not clearly indicate eligibility or ineligible status.

Systematic Alien Verification for Entitlement (SAVE) System Procedures

The SAVE System is the process of verifying an alien's immigration status by validating the alien's BICS documents through the Bureau of Citizenship and Immigration Service (BICS). Use telephone interaction between DHS and BICS using the BICS Alien Systematic Verification Index (ASVI) data base as the primary verification method when possible. Counties with touch-tone telephones have direct access to the ASVI data base. These counties will have a unique four digit identification number. Only those persons designated by the District Family Assistance Directors are permitted to access the ASVI data base.

The following steps are to be used to access the ASVI data base:

1. Dial the toll free system access number: 1-800-365-7620

2. Listen for the following message: "Welcome to the BICS ASVI System ..... (various messages). Please enter your authorization code followed by the pound sign (#)."

3. Enter the Authorization Code: *42*91*81*62----#

4. Listen for the following message: "Please enter the Alien Registration Number"

5. Enter the A-Number. Substitute a leading zero (0), if appropriate, for the leading "A".

6. A total of nine (9) digits must be entered to satisfy the Alien Registration Number response.

   Examples:

   An A-number having 9 numeric digits will be entered as A123 456 789= 123 456 789

   An A-number having 8 numeric digits will be entered as - A12 345 678 = 012 345 678

   An A-number having 7 numeric digits will be entered as - A1 234 567 = 001 234 567

7. Listen for further prompting from the "voice" to complete the verification process.

8. When another form of correspondence is needed to verify citizenship you may contact the United States Citizenship and Immigration Services (USCIS). This office may be contacted in writing by using Form G-845S.

   This should only be completed when you are:

   - unable to access SAVE; or

- the alien is not recorded in SAVE; or
- the documentation is question; or
- a discrepancy exists.

To contact USCIS you must:

- Complete Form G-845S for each applicant who was not born in the U.S. and has not provided satisfactory citizenship verification.
- Copy the verification used to establish satisfactory immigration status.
- Attach a copy of the verification to the form by stapling in the upper left-hand corner, using only one staple. Submit the verification and form G845S to USCIS at the following address:

  U.S. Citizenship and Immigration Services (USCIS)
  470-490 L'Enfant Plaza East SW, Suite 8001
  Washington, D. C. 20024

  Attention: Immigration Status Verification Unit

Documentary Evidence

Documentary evidence should be used whenever possible. The BICS has several types of documents that an alien might use to verify his/her status. Some of these documents are:

- Form I-151 or I-551 -- Alien Registration or a Re-entry Permit;
- Form I-94 -- Arrival/Departure Record. This record should be annotated with the specific term such as refugee, asylum or paroled;

Enumeration for Legal Aliens

As a condition of eligibility to receive TennCare Medicaid, applicants must either have or have applied for a Social Security number. Documented aliens who need to be enumerated in order to be eligible for our benefit programs may need our assistance in securing non-work Social Security numbers. SSA policy permits the issuance of Social Security numbers for people who do not have work authorization when a Social Security number is required to obtain benefits. To obtain this non-work Social Security number, an applicant must provide:

- evidence of age
- Identity

- Alien status, and

- Documentation from the appropriate government entity explaining the need for the Social Security number.

DHS is committed to assisting applicants in securing the documentation necessary for an application to be processed. Therefore, DHS county offices must provide an original letter to SSA on DHS letterhead stationery explaining why a non-work Social Security number is required.

Required Coverage for Citizens and Aliens

The Department of Human Services (DHS) must provide TennCare Medicaid to otherwise eligible residents of the United States who are:

- Citizens

- Aliens who are lawfully admitted under the color of the law

- Aliens granted temporary resident status if the individual is under 18, aged, blind, or disabled or a Cuban/Haitian entrant

- Aliens granted lawful temporary resident status under section 210 of the Immigration and Nationality Act unless the alien would but, for the 5-year bar to receipt of TANF contained in such section, be eligible for TANF.

- The Department of Human Services must only provide emergency services for pregnant women as defined in section 1916 (a) (2) (D) of the Social Security Act and services for pregnant women as defined in 1916 (a) (2) (b) of the Social Security Act to otherwise eligible residents of the United States who have been granted lawful temporary or lawful permanent status under section 245A, 210 or 210A of the Immigration and Nationality Act for five years from the date lawful temporary status was granted.

Coverage for Undocumented Aliens – Emergency Services

Undocumented aliens may be eligible only for emergency TennCare Medicaid services when all eligibility requirements other than citizenship and enumeration are met.

Undocumented aliens are eligible only during the emergency hospitalization or treatment period. Individuals who need ongoing routine care (i.e. dialysis, chemotherapy) are not eligible.

Emergency services are available only for individuals with sudden onset life threatening emergencies. Coverage will begin the day the individual is admitted to the hospital, or

emergency room for treatment. Treatment includes labor and delivery provided at a hospital or a birthing facility. All eligibility records that indicate the diagnosis and/or the reason the individual was admitted to the hospital will be maintained in the State Office.

Coverage under Medicaid will require individuals to have a sudden onset of an **acute** medical condition. Acute medical condition is a serious condition of short duration; for example:

- Heart attack
- Kidney failure
- Life threatening accident
- Allergic reaction
- Labor and delivery

Medicaid eligibility will begin the date of the hospital admittance, treatment in the emergency room, or birthing center and will end with the date of discharge. Coverage will no longer extend to the end of the month. DHS staff is required to inform these applicant/recipients that their coverage will end on the day he/she is released from the hospital, emergency room or birthing center.

Emergencies are usually defined as an illness that results in:

- Placing the Patient's health in serious jeopardy; OR
- Serious impairment to bodily functions; OR
- Serious dysfunction of any bodily organ part.

Eligibility may be determined either as categorically needy or medically needy based on TANF and SSI related policies for children or adults, respectively. For example: 185% of the Poverty Level Income Standard may be used for pregnant women, 133% for children under age 6, and 100% for children under age 19, and the Medically Needy Income Standards for children age 19 up to age 21. Budgeting of income follows more closely related category polices. Undocumented aliens will not have proper documentation to establish legal status.

Authorization of Eligibility for Undocumented Aliens

Eligibility is authorized by completing the TWISS data form and submitting original and two copies to Medicaid Policy, State Office, 400 Deaderick Street, Nashville, TN 37248-7350.

Please follow these instructions when completing the TWISS form:

- **Case Name**: This space located at the top right of the form should contain the name of the individual for whom the assistance is being authorized, not the head of the data base case or the household.

- In the space above the Case Name, enter:

    - The selected MCO. This is especially important for East and West Tennessee. In Middle Tennessee, the Bureau of TennCare usually assigns a MCO. For Middle Tennessee clients, enter "MCO—TennCare will select".

    - Country of Origin

    - Alien status: Undocumented. This is important as Refugee Assistance is also authorized on this form, and this entry will distinguish between the two.

    - Emergency problem, such as, surgery, delivery, etc.

- Line A: Enter transaction date, check Appr/Clos

- Line B: Enter complete address and county

- Line C:

    - Enter actual application date

    - Enter approval date

    - Approval reason – always 025110

    - Approval stat – 1

    - Closure date – always the first day of the month AFTER the coverage should end. For example, if the client is admitted to the hospital on 8-15-05 and released on 8-17-05, the closure date would be 9-1-05.

    - Closure reason – always 60058

    - Liv Arr—living arrangement – always U

    - Var code – always 1

- Line D:

    - Recipient ID – For new applicants, this number will always be assigned by the TennCare/Medicaid Policy Unit in the DHS state office. If this a repeat

authorization for this individual, use the number previously assigned by the TennCare/Medicaid Policy Unit.

- Name – PRINT LEGIBLY
- Name type – code to use can be found at the bottom of the TWISS document
- Date of birth
- Sex = Male—1, Female—2
- Race – code to use can be found at the bottom of the TWISS document
- Relationship – code can be found at the bottom of the TWISS document, but usually the individual is the head of his/her own case.
- Employment – code to use can be found at the bottom of the TWISS document
- Mres—medical resources, usually 0
- Elig – 5, Medicaid Only
- SS# - If there is a Social Security number, enter it. If not, one will be assigned by the TennCare Interchange system.

- When benefits are DENIED, a TWISS form is not completed.

- ***Notification***: A manual Notice of Disposition along with an Appeals Rights attachment must be sent to the client notifying him/her of approval or denial of benefits. Both forms are located in the GroupWise Default Library.

- ***Documentation:*** If an associated electronic case record should be documented with all the case specifics, including the date the manual notice was sent. If there is no associated ACCENT case, copies of all pertinent documents should be retained in a file folder.

FINANCIALLY RESPONSIBLE RELATIVES (FRR)

Policy Statement

Legal Base: 42 C.F.R. 435.602
State Rule: 1240-1-4-.17-(7)-(b)

Financial responsibility is limited to spouse to spouse and parent (legal) to child. Do not use the needs or income in the budget of a financially responsible relative who receives Families First, SSI or other public assistance. Do not deem any portion of a FRR's VA

(needs based) pension or other income used to determine the amount of the VA pension to budget group members.

Spouse to Spouse

The income and resources of the individual's legally married spouse are considered available to him/her whether or not actually contributed:

- While the couple live together, including temporary absences; AND
- During the first month of separation by one member's admission to a medical institution; UNLESS
- The couple had been living apart for at least six months prior to their separation.

A couple residing in a separate or the same room in a long-term nursing care facility are not considered as sharing the same living arrangement and are treated as individuals with no deeming of income or resources.

Financial responsibility by the ineligible or eligible spouse ends the month of separation for any reason such as admission to a medical institution when 30 days continuous confinement is met or for individuals applying to enroll in HCBS, the individual is determined to need and to be likely to receive services for a continuous period of at least 30 days going forward. If the individual or his/her spouse applies for TennCare Medicaid in the month of separation, his/her eligibility is determined as an individual only. At that point, only resources and/or income actually contributed to the individual are considered available to him.

Eligible Couple Status

A couple is considered an "eligible couple" when they share the same living arrangement in the community and have either:

- Both applied for TennCare Medicaid, or

- Both are eligible as aged, blind, or disabled individuals

A spouse is defined as:

- An individual's legally married spouse, or

- An individual determined by the SSA to be eligible to receive Social Security benefits as the spouse of another, or

- An individual's "holding out" spouse.

  A "holding out" relationship exists when an unrelated man and woman presents themselves to the community as husband and wife in the absence of a legal

marriage. EXCEPTION: However, for Spousal Impoverishment Allocation, the marriage must be legal or a common-law marriage established in a state which recognizes it as a valid marriage. However, for Qualified Medicare Beneficiary (QMB) individuals, legal marriage only is considered in determining who is a spouse.

Determining of Marital Relationship

Accept the individual's statement regarding his marital status if he is married, unmarried or separated from his spouse. Obtain written verification of divorce, e.g., copy of divorce decree or other verification and substantiate this through a collateral contact.

Consider the individual to be married when:

- He states he is legally married, or
- Both individuals state they present themselves as married (a "holding out" relationship), or
- Results of a "holding out" interview indicate a "holding out" relationship.
- A "holding out" relationship exists when a man and a woman live together and present themselves to the community as man and wife in the absence of a legal marriage. When an individual is living with an unrelated person of the opposite sex and cannot satisfactorily explain the reasons for living together but denies a "holding out" relationship, conduct a "holding out" interview to determine the nature of their relationship.

"Holding Out" Interview

Interview both parties and document the responses of both parties to the following questions:

- By what name or names are you known?
- How do you introduce the other person to friends, relatives, others?
- How is mail addressed to you, to the other person?
- Are there any bills, installment contracts, tax returns or other papers showing the two of you as husband and wife?
- Is your residence owned or rented by one or both of you? Furnish the names on the deed or lease.

When both sets of responses indicate the individuals do not present themselves to the community as husband and wife, do not consider them to be married provided they provide one piece of evidence to support their allegation.

If one or more answers indicate a "holding out" relationship, consider the couple to be married. The assumption can be rebutted by the couple by sufficient and valuable evidence to the contrary. The following items can be used as evidence to deny a "holding out" relationship:

- Will
- Passport
- Property deed
- Lease/rental agreement
- Insurance policy
- Mortgage papers
- Bank account
- Credit cards
- Passport
- Statements from friends and relatives.

Parent to Child

The income and resources of the legal parents of the child under age 21 are considered available to the child in determining his/her financial eligibility when:

- The child and the parent(s) live together; AND
- During the child's temporary absence from the home, EXCEPT FOR
    - Children in Special Living Arrangements:
    - Foster Care
    - Subsidized Adoptions
    - Inmate

NOTE: The child's admission to a psychiatric facility is considered a temporary absence. Psychiatric care is not considered institutionalization for purposes of determining the under age 21 individual's separation from his/her financially responsible relative (parent or spouse).

Parental financial responsibility is limited to the legal parent. Do not assume responsibility (deem income/resources) from the alleged father or stepparent even if he/she lives in the home with the child. Count only the alleged father's or stepparent's actual financial contribution.

Other Relatives

There are no additional financial responsibilities for any other relatives including stepparents other than the spouse/parental provisions set forth here.

The income and resources of the spouse or parent not living in the same household with the individual are considered available to him/her to the extent they are actually contributed.

Failure to Provide Financial Information

The failure of the financially responsible relative(s) to provide information regarding his/her income and resources results in the ineligibility of the applicant/recipient during the period such assets would normally be considered available to him/her.

Verification of Financial Information

Income

Follow the procedures in the Income Chapter regarding the collection of and verification of the relative's income.

Resources

Follow the procedures in the Resources Chapter for the collection of information regarding the relative's resources including establishing ownership and determination and verification of resource value.

INSTITUTIONAL STATUS

Policy Statement

Legal Base: 42 CFR 435.1008 and 1009
P.L. 97-35, Section 2176 of the Omnibus Budget Reconciliation Act of 1988

TennCare Medicaid benefits and vendor payments are available to the aged, blind, or

disabled individual currently confined for at least thirty (30) consecutive days to a medical institution (including services in a hospital, nursing facility, intermediate care facility, or intermediate care facility for persons with mental retardation) and/or enrolled in an HCBS program or any combination thereof that has been continuously received for at least 30 consecutive days if he is not an inmate or in a mental institution; or for individuals applying to enroll in HCBS waiver program, the individual is determined to need and to be likely to receive services for a continuous period of at least 30 days going forward and any individual who dies while in a long term care nursing facility prior to 30 days continuous confinement.

A vendor payment may be authorized for individuals already eligible for TennCare Medicaid coverage when they become institutionalized for less than 30 consecutive days. These may be SSI eligible individuals or those who are eligible under any of the TennCare Medicaid coverage groups for which DHS determines eligibility, EXCEPT Qualified Medicare Beneficiary (QMB) and Qualified Disabled Working Individual (QDWI).

Institutions

An institution is an establishment that provides food, shelter, treatment and/or services to four or more individuals. Types of institutions include:

Medical Institution

An institution authorized by State law and organized to provide medical care including nursing and convalescent care. Examples of medical institutions include: hospitals, convalescent or progressive care centers and long-term care facilities (LTCF), both skilled and intermediate care.

Institution for the Mentally Retarded (IMR)

An institution organized primarily for the diagnosis, treatment or rehabilitation of the mentally retarded and providing a protected residential setting for the evaluation, rehabilitation and 24-hour supervision of the patient.

Institution for Mental Diseases (IMD)

An institution licensed to provide diagnosis, treatment or care of persons with mental diseases.

NOTE: TennCare Medicaid reimbursement is limited to care provided an eligible individual who is at least 65 years of age and confined to an approved ward. IMD confinement does, however, satisfy and establish institutional status for individuals under age 65 and/or those confined to unapproved wards who are subsequently admitted to a medical institution. For example, an individual transferred from an IMD to a Title XIX medical institution has satisfied the

institutionalization requirement during his IMD confinement even though he was not eligible for TennCare Medicaid during that confinement period.

Public Institution

An institution serving more than 16 residents that is the responsibility of or controlled by a governmental unit. NOTE: HCBS are considered a form of institutionalization although services are provided in the individual's home or a facility converted for this type of service. A public institution does NOT include:

- a medical institution,
- an intermediate care facility including those providing services to individuals age 65 and older in institutions for tuberculosis or mental diseases.

Institution for Tuberculosis (TB)

A facility established and maintained primarily for the care and treatment of tuberculosis. NOTE: The facility need not be licensed for such care. Tennessee does not have any chest disease or TB hospitals. Reimbursement is available to an out-of-state hospital for the Tennessee resident.

Confinement

Confinement means admission to an institution to live or enrollment in a HCBS project and to receive treatment or services as required. Throughout this section, the term "confinement" and the phrase "in an institution" are used synonymously.

The confined individual may be referred to as a:

- Patient
- Resident
- Institutionalized individual

Continuous Confinement Requirement

42CFR 435.722(C) HCFA Transmittal MCD-9-84 (2000)

Confinement means admission to an institution to live or enrollment in a HCBS project and to receive treatment or services as required. Throughout this section, the term "confinement" and the phrase "in an institution" are used synonymously.

The confined individual may be referred to as a:

- Patient
- Resident

- Institutionalized individual

Home and Community Based Services (HCBS) Project

HCBS is authorized by a waiver of TennCare Medicaid statutory requirements. In this program (Refer to the Chapter on HCBS for more information):

- Services are provided to individuals in their own homes or in a facility participating in the HCBS project who would otherwise require the level of care provided in an Intermediate Care Facility (ICF);

- Services are required to be furnished under an individual written plan of care; and

- Individuals enrolled must meet the same eligibility criteria as if admitted to an ICF.

Inmate

Inmate means a person living in a public institution except for:

- The individual in a public educational or vocational institution for the primary purposes of educational or vocational training designed to prepare him for gainful employment, or

- The individual temporarily confined pending other arrangements appropriate to his needs, or

- The individual receiving medical treatment in a ward approved by the DHE.

Inmate means ANY person living in a public institution who was committed under the penal system with NO exceptions. Inmate status is interrupted or terminated when an individual is admitted as an inpatient to a medical institution except for those committed under the penal system. Inmate status for those committed under the penal system terminates upon release from custody. Release means:

- Parole
- Pardon
- Bail
- Dismissal of charges

Patient in an Institution for Mental Diseases (IMD)

A patient means an individual receiving professional services in an institution for mental diseases but does not include an individual on conditional release or convalescent leave from such an institution.

Verification of Institutional Status

Establish the individual's institutional status using any one of the following methods or evidence as appropriate. Document the electronic case record following standard case documentation procedures.

Confinement to a Medical Institution (Hospital or similar institution)

Check with the hospital admission office either by phone or written correspondence to verify admission/discharge dates. Review the individual's bill for hospital charges as it includes an admission and sometimes a discharge date.

Long-Term Care Facility

Participating facilities will use Form 2350, Notice Recipient-Patient Admitted to or Discharged from Skilled Nursing Home Care or Intermediate Care, which is completed by the admitting facility and is forwarded to DHS. For non–participating facilities, check with the facility either by phone or written correspondence to establish admission and/or discharge dates. Bills for LTCF services provide admission and/or discharge dates.

Confinement to an Institution for Mental Disease

Form 2350 (see above) from a DMHDD facility is sufficient evidence that the unit to which the individual was admitted is one qualified for TennCare Medicaid reimbursement. Review the voluntary admission form the individual signed prior to admission to substantiate that individual is not an inmate.

Enrollment in HCBS project

The community agency which is providing the service to the individual will submit a Form 2350 to DHS. The PAE date will be shown on the Form 2350 to verify enrollment in the HSBS project.

Types of LTCF Qualifying For TennCare Medicaid Vendor Payments

TennCare Medicaid reimbursement (vendor payment) is available for care provided in the following institutions:

- State Developmental Centers for the Mentally Retarded, including certified ICF/MR wards for patients of any age and certified SNF wards for patients of any age.
- State and Private Certified Mental Health Hospitals
- Licensed Public and Private Nursing Homes, including Intermediate Care Facility for patients of any age and Skilled Nursing Care Facility or patients of any age.

Institution for Mental Diseases (IMD)

Medicaid reimbursement for patients confined to an IMD is limited to care provided for an individual who is at lease age 65 and confined to an approved ward.

IMD confinement does satisfy and establish institutional status for individuals under age 65 and/or those confined to unapproved wards who are subsequently admitted to a medical institution, for example an individual transferred from an IMD to a Title XIX medical institution has satisfied the institutionalization requirement during his IMD confinement even though he was eligible for Medicaid during that confinement period.

Coverage for Former Patients' Inmates of Institutions For Mental Diseases

A qualifying individual who is no longer an IMD patient OR has had his inmate status interrupted may be eligible for TennCare Medicaid benefits upon his admission to a medical institution that is a Title XIX facility. Interruption of IMD patient status occurs when the individual is released, transferred, or on convalescent leave form an IMD. Inmate status is interrupted when an individual is admitted to a medical institution UNLESS he was admitted under the penal system which requires release from the institution, i.e. parole, pardon, bail, or dismissal of charges.

An individual may qualify for TennCare Medicaid benefits as an institutionalized individual when his patient/inmate status in one of the following public institutions is interrupted:

- Lakeshore Mental Health Institute, Knoxville
- Memphis Mental Health Institute, Memphis
- Middle Tennessee Mental Health Institute, Nashville
- Western Mental Health Institute, Bolivar
- Moccasin Bend Mental Health Institute, Chattanooga

As applications are processed for this group, refer any individuals who might qualify for cash assistance to the SSI program. Eligibility for cash assistance includes a cash payment as well as TennCare Medicaid benefits for these individuals where TennCare Medicaid benefits in this coverage group extend only to the institutionalized individuals. These individuals must follow all procedures for filing an application for assistance and must meet all technical and financial requirements as detailed in this Manual.

In general, the IMD representative will arrange for placement in a medical institution and will develop a plan with either the individual's family or the medical facility to apply for TennCare Medicaid. Because of the individual's former patient/inmate status, the DHS caseworker should be able to secure all necessary information from a representative of the IMD. The IMD representative will file an application in the patient's behalf and act as the responsible person for the patient.

If the caseworker is unable to establish eligibility due to insufficient information or verification, notify the patient's representative at the IMD and allow 15 days for the representative to secure the necessary information/verification. If the additional 15 days causes the application to be held pending beyond the processing time limit, this is beyond the caseworker's control, provided he/she has acted promptly heretofore.

Eligibility begins the first day of the month in which all eligibility requirements are met. Eligibility ends the last day of the month in which the individual is discharged from the medical institution and fails to meet eligibility requirements for other TennCare Medicaid categories.

Children in Residential Treatment Centers

Children who enter residential treatment facilities, such as those for sex offenses or alcohol/drug abuse and they are in the custody of a parent or a caretaker relative in the specified degree of relationship may be eligible in their existing eligibility group. Children in this situation should still be considered a permanent resident of the home with the family and eligibility should be determined with the child in the household in the home county.

When a child is ordered by the Juvenile Court or by his treating physician to undergo a psychiatric evaluation or treatment for a sex offense, alcohol and drug abuse, or some other type of residential treatment, the cost of care is the responsibility of the child's family if the child remains in the custody of his parents or other caretaker relative.

If the family cannot afford to pay the cost of care the family may apply for medical assistance. If the child is currently eligible as a family member, we can continue the Medicaid in his/her current category based on the temporary absence provision as outlined in Part VI section H in this same chapter; however, apply this same provision for children who are in approved treatment centers for in state or out of state facilities.

Listed below are examples of treatment facilities that provide these types of services:

- Parkwood Behavioral Health System – located in Mississippi
- Hermitage Hall – located in Tennessee

Once it has been reported to DHS that a child has been placed in a treatment facility, and the child has been out of the home for more than three months, the caseworker will request a treatment plan and complete the following:

- Obtain the client's anticipated date of release from the treatment facility and return to home.

- Follow up with the client within five (5) working days of the anticipated date of return.

- If a review is required during the period of absence, follow review procedures and secure assistance from the other state if necessary.

- If at any time during the absence it is determined that the individual is no longer eligible for benefits (for any reason), take steps terminate the child's benefits.

If the family loses eligibility for reasons other than temporary absence of the child, the child will lose eligibility also.

INCOME

Policy Statement

Legal Base: 20 CFR 416.1103

Income falls into two broad categories: earned and unearned. The following chapter addresses both types of income including examples of each and instructions regarding the counting, evaluation and verification of each type of income.

Items Which Are Not Considered Income

Generally speaking, anything the individual receives that cannot be used in exchange for food, clothing or shelter is not considered income. The proceeds from the sale or exchange of a resource (real or personal property) are not considered income but may be considered resources depending on the circumstances of the situation. Medical care and services are **not** considered as income if any of the following apply:

- Services provided free or paid directly to the provider by a third party (including insurance)
- Any assistance provided under a Federal, State or local medical care/vocational rehabilitation program.
- Non-governmental medical services excluding food, clothing and shelter.
- Cash payments made by a medical insurance policy as repayment of services already provided. **NOTE:** These payments are third party medical resources and such must be reported to the TennCare Bureau.
- Direct payment of the client's medical insurance premiums by a third party.

Social services are not income if any of the following apply:

- Assistance in cash or kind under a government program whose purpose is to provide social and or vocational rehabilitation services, e.g. Aid and Attendance Allowance paid by the Veterans Administration.
- Cash provided by a non-governmental social service program to cover program approved services the individual has already paid for, e.g. the cash payment provided to purchase homemaker services.
- Receipts from the sale, exchange or replacement of a resource.

- Income Tax Refunds.
- Payments by credit life or credit disability insurance.
- Proceeds of a loan.
- Borrowed money is not income. In some situations, principal and/or interest repayments on loaned money are income. See the Unearned Income section of this Chapter for a further discussion of this subject.
- Third Party Payments. Any expenses paid for the individual by a third party directly to the vendor or provider of services, except for payments for food, clothing or shelter, are not considered in determining income eligibility.
- Replacement of lost, stolen or destroyed income the individual already received.

EARNED INCOME

Earned income is the compensation an individual receives for the performance of services or as a result of his own efforts either as an employee or through self-employment.

Earned income includes all wages, salaries, bonuses or commissions earned while employed by another person and all net earnings from self-employment and any compensation the individual receives in-kind.

Earned Income Types

The following is a list of the types of income that are considered to be earned income. This list is not all inclusive.

- Cash tips over $20.00 per month.
- Payments made by an employer or union including annual/vacation leave, dismissal pay, holiday pay, idle pay, severance pay, sick leave pay, stand-by pay, and strike pay. NOTE: A parent on strike the last day of a month renders the entire family ineligible for TennCare Medicaid except for PLIS categories for pregnant women and infants.
- Farm Income
- In-kind earned income. This may include the value of food, clothing or shelter (or other items) provided by an employer, unless the employee is/was a domestic worker.
- Employer Reimbursed Business Expenses. Travel pay and reimbursement for other business expenses are earned income if they are included in the individual's regular

pay with no specific identification or separation or when the amount paid exceeds the actual incurred costs.

- Net earnings from self-employment enterprises including farm, rental, and roomer-boarder income.

- Rental income, when the owner/purchaser is actively engaged in producing the income (including managerial responsibilities).

- Royalties and honoraria will be treated as earned income.

- Sheltered Workshop Earnings. Under some circumstances, income earned by TennCare Medicaid patients in a nursing home may be considered therapeutic. These individuals are recognized as a group who have a greater need for a personal income, because of the nature of their activities. Retention of additional income derived from work is considered essential for achieving a degree of independence. Therefore, up to $100 is excluded from gross income in determining patient liability for ICF-MR and other long-term nursing care patients.

- Count income received from Title V Older Americans Act if wages are received for services. (SI 00840.210.230)

- Any local Native American tribal funds that a tribe distributes to individuals on a per capita basis (e.g. tribal gaming revenues) are considered as income and resources. (SI 0830-830)

Excluded Earned Income

- Certain types of income are excluded in their entirety by Federal laws in addition to those exclusions provided for in the Social Security Act. Exclude these types of income in determining eligibility:

- Wages, allowances or reimbursements paid under Title VI of the Rehabilitation Act of 1973 (PL No. 95-602).

- Certain revenues paid to Native Americans.

- Undergraduate grants or loans under Section 507 of the Higher Education Amendments of 1968 (PL No. 09-575). Exclude the amount of College Work Study used to purchase books, supplies, transportation and miscellaneous personal expenses.

- Compensation provided volunteers under the Foster Grandparent Program and similar programs under the Domestic Volunteer Service Act of 1973.

- Earnings received to fulfill an approved plan to achieve self-support (PASS) for disabled or blind individuals.

- Non-cash items provided to a budget group member but paid by a non-budget group member, including an agency or organization, directly to a provider are excluded as income.

Earnings of a Child who is a Member of the Budget Group

Categorically Needy Groups

Do not count the earned income of a minor full-time student. **Do not count** his/her income in computing eligibility for Medicaid and TennCare standard. If a child is not attending school and is not an emancipated minor his/her income may be disregarded for six calendar months per year.

A **student is defined** as a minor child recipient attending primary/secondary school, college, university, or a course of vocational or technical training full time and, receiving elementary/secondary or equivalent vocational/technical instruction from a homebound teacher and meets the student requirement.

A child his/her retain student status during official school vacations and breaks if the requirement prior to the vacation/break were met and the student plans to return after the school break.

An elementary school is defined as a state approved educational institution comprised of grade kindergarten through eight

Participation in apprenticeships, correspondence courses, other courses of home study and rehab programs other than academic or institutional vocational or technical training **do not** qualify a child as a student.

Medically Needy Groups

Exclude from the budget group's countable gross income the earnings of a child who is a member of the budget group who received JTPA earnings, **and** earnings of a child who is a fulltime student or a part time student not employed fulltime.

Other Earned Income Exclusions: Work Expenses for Non-Institutionalized Adults

These exclusions are applied to earned income in determining eligibility of a non-institutionalized adult and to the SSI-Related budgeting groups only, such as, SSI Pass Along/Pickle. These earned income exclusions do not apply to eligibility of an institutionalized individual determined under the Medicaid Income Cap.

Apply the work expense exclusions in the following order:

- Exclude any portion of the $20 general disregard not applied to unearned income.
- Exclude the first $65.00
- Exclude one-half of the remaining earned income.
- If the individual is under age 65 and eligible based on his blindness, deduct any expenses reasonably attributed to the production of his income.

Irregular or Infrequent Income

Earned income can be excluded as infrequent or irregular when it meets **all** of the following criteria:

- It does not exceed $10.00 per month per individual or couple.
- It is received only once a quarter.
- It cannot reasonably be expected to be received again or is earned from employment that is on an "as needed" basis.

In-kind Wages

In-kind wages are the value of food, clothing, shelter or other items provided to the client by his employer instead of or in addition to cash. Count in-kind wages available to the individual the earliest of the following:

- When they are received, OR
- When they are constructively received, i.e., credited to the individual's account or set aside for his use.

Value in-kind wages at the current market value of the time(s) received less the amount of the outstanding balance due on the item, if any. The current market value is equal to the price of the item on the local open market. Secure a statement from the individual's employer that includes all of the following:

- A specific identification of the item paid in-kind,
- The balance due, if any, on the item,
- The date the in-kind wages were paid.

Sick Pay as Earned Income

Any payment made by an employer or third party (e.g., insurance company) due to sickness, accident or disability is considered earned income if received in the first six months after the individual stopped working.

NOTE: Payments as described above but received more than 6 months after the individual last worked are considered to be unearned income. Refer to the Unearned Income section in this Chapter for more details.

Wages

Wages includes all remuneration from employment, and the term is broadly defined to mean gross wages. Gross wages are the amount paid before the deduction of taxes, garnishments, pension fund contributions, and other optional deductions such as insurance premiums, savings bonds, loan repayments etc. Gross earnings are the total compensation received for the performance of services while in the employ of another including wages, salaries, bonuses, or commissions.

Net Earnings are the amount of earnings remaining after mandatory deductions such as Federal Withholding taxes and Social Security taxes and other types of deductions have been withheld. Mandatory deductions for FICA and withholding taxes are excluded from earned income of institutionalized individuals in determining eligibility and patient liability. For program purposes, net earnings equal the amount of income remaining after application of the earned income disregards.

NOTE: Earned income disregards are detailed in the Budgeting Methodology section of the Treatment of Income and Budgeting Chapter.

Wages are counted (considered available to the individual) at the earliest of one of the following:

- when they are received or paid; or
- when they are credited to the individual's account; or
- when they are set aside for the individual's use.

Deferred wage payment occurs when wages are paid at a time later than they normally would have been paid. If wage payments are deferred due to circumstances beyond the employee's control, consider the payment earned income when it is actually available to him. If the wage payment(s) is deferred at the employee's request, determine when the wages would normally have been paid and consider them earned income for that period.

Contractual Income

To calculate contractual income, average the full amount of income paid on a contractual basis over the number of months the contract covers.

Verifying Wages

To verify earnings secure at least one of the following:

- The paycheck stubs for the period under consideration; or
- A statement from the individual's employer that includes at least the following information:
  - date earnings were paid
  - the gross earnings
  - specific identification of any withheld earnings
  - tips reported
- The individual's signed statement regarding the amount of tips earned
- When it is directly deposited to his account.

Self-Employment/Partnership Venture

Federal Income Tax Returns

Self-employed individuals report their Net Earnings from Self-employment (NESE) on federal income tax returns. NESE is the gross income from any trade or business less allowable deductions for that trade or business. NESE also includes any profit or loss in a partnership. For the purposes of determining financial eligibility for TennCare Medicaid, count the NESE on a taxable year basis and divide the total of these earnings equally among the months in the taxable year to get the earnings for each month. For example, if net earnings for a taxable year are $2,400, consider that $200 was received each month.

Verify NESE whenever self-employment is alleged or otherwise indicated, unless the individual:

- Alleges starting a new business and that he/she was not self-employed in the prior taxable year; or
- He/she has applied for or is receiving Title II (Social Security) benefits.

Using the federal income tax return, verification of NESE is found on Schedule SE (Self-employment). The self-employed and certain church employees use schedule SE (self-employment) to compute their Net Earnings (or loss) from SE for Social Security tax purposes.

Net earnings – Section A, line 4 or Section B, line 4.c. If line 4 or 4.c. shows a positive amount of less than $400, then line 3 is used. Even if the amount on line 3 is greater than

$400. For example: line 3 shows $410 and line 4 or 4.c shows $378; line 4.c. should be used because no tax was due.

NOTE: Other Schedules (C, C-EZ, F, etc.) can be reviewed to see the net profit or loss for the business but are only used to determine what business is being reported as self-employment.

Depreciation

In computing NESE, a deduction may be taken for a reasonable allowance for depreciation, i.e., the decrease in value of an item of property through wear, deterioration, or obsolescence. Accept the amount of depreciation shown on a tax form, unless an item of depreciation raises a question of propriety.

EXAMPLE: A minister deducts as an expense his ordinary and necessary expenses such as investments, stationary, stenographic help and travel expense. In the year 2001, he purchased new Bibles and Hymnals. Since books and equipment have a useful life of more than one year, they are considered capital assets. The entire cost may be not deducted in the year of purchase, but the cost could be recovered in the following years through depreciation.

Partnership

Any distributive share (whether distributed or not) of income or loss from a trade or business carried on by a partnership is included in NESE, unless specifically excluded.

- The guaranteed salary is allowed as a business deduction in computing partnership income.
- The receiving partner is not considered an employee of the partnership.
- Guaranteed salary payments are not "wages" but NESE.

Count the NESE when determining income derived from self-employment.

Capital Gains

Money received from Capital Gains or Losses from the sale of capital assets is not income.

EXAMPLE: Mr. Smith's business is farming. Mr. Smith owns 4 farms and reports all income received from his farming enterprise on his federal income tax return filed in 2001. Mr. Smith sold one of his farms for $100**,**000 in May 2002. The money received from the sale of his farm is not considered as income when determining eligibility for TennCare Medicaid. For purposes of TennCare Medicaid, the money he received from the sale of his farm is counted as a resource**.** It is considered a conversion of a resource (the exchange of an excluded resource for a countable resource).

For purposes of TennCare Standard, Capital Gains are excluded because resources are not considered for applicant/recipients of TCS.

When Mr. Smith files his federal income tax return for 2002, IRS will compute his taxes based on his income and his capital gains and losses. In determining his income for TennCare Medicaid, only consider the NESE and divide it by 12 to arrive at a monthly figure.

Schedule D (Capital Gains and Losses) is used to report both short-term and long-term capital gains and losses from partnerships, Subchapter "S" corporations and fiduciaries.

Schedule E (Supplemental Income and Losses) is used to report both short-term and long term capital gains and losses from partnerships, Subchapter "S" corporations.

Schedule F (Farm Income and Expenses) is used to report income and expenses from a farm operation.

Schedule K1 (Form 1065) Partner's Share of Income, Credits, Deduction, etc. is used by a member of a partnership, joint venture, or a shareholder in a Subchapter "S" corporation to recapitulate the income or loss allotted by the business to that individual. This amount is then shown on that individual's SE. This form is not filed with the tax return because the business enterprise has filed an information return showing the amount allotted to each member.

Form 1065 (U.S. Partnership Return of Income) is used by the partnership to report income and deductions.

Form 1120 (U.S. Corporation Short-form Income Tax Return) is used generally by corporations that have gross receipts, total income, or total assets under $500,000 to report profit and loss. If the applicant/recipient cannot provide an income tax return, accept:

- Business Records

  When business records are used to arrive at the NESE, use the individual's gross income and allow the applicant/recipient the same deductions that are allowed by IRS to determine the NESE. (This includes any business-related expenses, including depreciation.)

Please use business records when a federal income tax return is not available, or the individual has made changes, stopped or added to the business.

- Individual's Signed Allegation

  If acceptable evidence of NESE cannot be obtained any other way, you may accept the applicant/recipient's signed allegation.

Consider all factors in the case when an individual alleges participating in an activity that produces income to determine if it constitutes self-employment.

Please remember to use the NESE from the correct schedule in determining income for self-employment. **IRS has already deducted any business-related expenses including depreciation**. If the applicant/recipient cannot provide an income tax return but is using business records and claims depreciation as a business deduction, please remember depreciation is an allowable deduction for TennCare Medicaid and TennCare Standard.

Data Base Procedures

Because depreciation is an allowable deduction for TennCare Medicaid and it is not an allowable deduction for Food Stamps or Families First, please use the following procedure when an individual reports income from self-employment.

For individuals applying for TennCare Medicaid and Food Stamps: Please enter depreciation expenses under self employment data as 'employer FICA share' since this is an allowable deduction for TennCare Medicaid, but is not an allowable deduction for FS. This should ensure the budget is correct for both programs without having to process an override on the case.

For individuals applying for Families First and TennCare Standard, when income of an individual must be counted in both Aid Groups, contact the ACCENT help desk.

Farm or Rental Income As Earned Income

Farm and/or rental income is considered earned income when the individual materially participates in the production of the income.

Farm Income Defined

Farm Income is defined as:

- an arrangement between the client and another person whereby the other person produces the agricultural or horticultural commodities on the land the client owns or leases; AND

- the commodities produced or the income from the sale is divided between the client and the other person; AND

- the amount of the client's share depends on the amount of commodities produced; AND

- the client periodically advises, instructs or consults the other person and inspects the production activities and furnishes the machinery, tools, livestock or advance monies required in the production of the income.

Rental Income Defined

Rental income is considered earned if the individual is a real estate dealer or property owner engaged in the business of buying/selling real estate for profit and he receives rental income from the investment property.

Counting Farm/Rental Income that is received on a regular basis

Federal Income Tax Return Available

If you have used a Federal tax return to verify earnings, prorate the reported annual profit over 12 months. Count the result (the monthly amount) as earned income taking into account any anticipated changes for the prorated period. For example, a landlord has increased the rental charge by $20 a week but anticipates renting the same number of weeks as the previous year.

Absence of a Federal Income Tax Return

Verify the gross annual income from the previous year and deduct any of the applicable allowable expenses cited in this Chapter that have been verified. Prorate any resulting profit as described above.

Counting Farm/Rental Income Received Annually or Infrequently

If the farm or rental income is received on an annual or infrequent basis, prorate the annual amount with anticipated changes over 12 months and count the monthly amount as earned income.

Verifying the Amount of the Farm/Rental Income

Verify the amount of rental/farm income using at least one of the following verifications:

- For Rental Income:
    - Secure a copy of the rental/lease agreement in effect during the period under consideration.
    - Secure a statement from the renter indicating the amount and payment date of rental amount.
    - Secure a copy of the receipt the client prepared upon receiving rental income.
    - Secure a copy of the previous year's Federal income tax return.
- For Farm Income:
    - Secure a copy of the agreement executed by the client and the individual working the farm.
    - Secure a copy of the most recent profit/loss statement.
    - Secure a copy of the previous year's Federal income tax return.

UNEARNED INCOME

Unearned income is money an individual receives that is not the result of his current work efforts but accrues to him as the result of investment, inheritance, previous work efforts, etc.

The following is a list of types of items considered unearned income. This list is not all inclusive:

- Annuities, Pensions and other Periodic Payments
- Dividends, Interest and Royalties
- Rental and Farm Income
- Proceeds of Life Insurance
- Prizes and Awards
- Gifts and Inheritances
- In-kind support and maintenance
- Income Deemed from a Financially Responsible Relative
- Contributions
- Alimony and Support Payments
- Sick/Disability Payments
- Payments Received on an Unavailable Asset
- Death benefits in excess of cost of last illness or burial
- Strike Benefits, Worker's Compensation, and Unemployment Compensation
- Trust Fund Proceeds
- VA benefits

When Unearned Income is Counted

Count unearned income available to the individual at the earliest of the following:

- When he receives it; OR
- When it is set aside for his use

Exception for Direct Deposits

Advance dated checks directly deposited/posted into an individual's bank account before the month of normal receipt are considered income in the month of normal receipt, not the month of deposit or posting.

EXAMPLE: A Social Security check for February may be directly deposited into the bank during the last working day of January. This is not income or a resource in January, but is counted as income in February and as a resource, if retained, beginning in March.

Countable Portion of Unearned Income

When to Count More than the Client Actually Receives

Count more than the individual actually receives when any of the following conditions exist:

- A benefit payment is reduced to recover a previous overpayment; unless Medicaid eligibility was based on the amount of benefit paid during the period the overpayment occurred.

- A payment reflects a garnishment.

- A payment is reduced to make certain payments, e.g. Medicare premiums deducted from a Social Security benefit payment, other medical insurance premiums, or life insurance premiums.

- Income is deemed available from a financially responsible relative and the individual claims he does not have access to or receive any contribution from that relative.

- Gross income from the Veterans Administration (VA) must be used when the following deductions are made from the income:

    - for insurance purposes
    - for debt payments for VA loans
    - to recover miscellaneous overpayments
    - for tax liens or other government debts
    - paid into a veteran's account at an institution
    - to recover severance pay.

- The following deductions are made from the individual's unearned income:

    - federal, State, or local income taxes
    - union dues
    - loan payments
    - service fees charged on interest-bearing checking accounts

- inheritance taxes
- guardianship fees, if presence of a guardian is not a requirement for receiving the income
- court-ordered or voluntary alimony payments

NOTE: Mandatory deductions such as FICA and withholding are excluded from pensions and other unearned income in determining eligibility and patient liability for institutionalized individuals.

When to Count Less than the Client Receives

Count less than the individual actually receives when any of the following occurs:

- Expenses Incurred Securing Income

  Exclude the amount of any verifiable expenses the individual incurred in getting the money, i.e., legal fees, medical and other expenses attendant to a damage claim or guardianship fees. Subtract these expenses from the first and any subsequent amounts of related income until the expenses are completely eliminated.

- Augmented VA Benefits

  Exclude the amount of VA payment that has been augmented to include a payment made on behalf of a dependent or dependents.

- **VA Aid and Attendance Allowance**

  Exclude the amount of any VA payment identified as an Aid and Attendance allowance in determining an individual's income eligibility. This income is also excluded in patient liability when authorizing TennCare Medicaid vendor payments to the individual confined to a long-term care facility.

- **VA Payments resulting from Unusual Medical Expenses (UME)**

  Exclude the amount of any VA payment identified as being received due to unusual medical expenses when determining an individual's income eligibility. UME is non-reimbursable medical expenditures that exceed 5% of the applicable maximum annual VA payment rate. The reimbursement for these medical expenses may result in a higher monthly VA payment, an extra payment, or an increase in a payment. For institutionalized individuals, in the post-eligibility determination of patient liability, these VA payments resulting from unusual medical expenses are also excluded.

- **Life Insurance Proceeds**

  The amount as paid for medical and/or burial expenses from the proceeds of life insurance is excluded as income.

- **HUD-Financed ICF-MR**

  Exclude any rent subsidy financed by HUD and paid to individuals in certain ICF-MR facilities.

Note: Exclude mandatory deductions, such as FICA and withholding tax on pensions and other unearned income for institutionalized cases only in the eligibility and patient liability determinations.

Unearned Income Excluded By Federal Law

Exclude the following types of unearned income to determine income eligibility (i.e., Medically Needy for children and pregnant women, Categorically Needy adult categories, and gross income test for institutionalized individuals).

- Refund of taxes on real property or food
- Earned Income Tax Credit (EITC) Payments
- Assistance based on need which is entirely funded by the State or one of its political subdivisions. NOTE: This does not include programs funded entirely by Federal Funds or by a Federal/State grant program, such as Families First.
- Retroactive Families First or SSI payments
- VISTA payments
- Food raised by the individual and/or spouse for their own consumption
- Assistance received under any Federal statute because of a catastrophe including the Disaster Relief Act of 1974
- Infrequent or Irregular Income

  Up to $20 per month individual/couple unearned income can be excluded as infrequent or irregular when it meets the following criteria:

  - it is received only once in a quarter from one source, e.g., one individual, household, organization or investment. AND
  - it cannot reasonably be expected to be received on a regular basis.

  NOTE: Infrequent or irregular income is not counted in determining patient liability for institutionalized individuals.

- Casual and inconsequential income (monetary gifts/contributions not exceeding $30.00 per calendar quarter) received by each recipient.

- Foster care payments for a child placed by a public or non-profit child placement or child care agency.

- Exclude child/spousal support payments transferred by the budget group to the IV-D agency as assigned support.

- Exclude up to $50.00 per month child support received by a family. (This exclusion is applied for each family regardless of the number of budget groups within a family.)

- One-third of absent parent support payments received by an institutionalized individual who is under age 18.

- Exclude from countable income legally obligated payments otherwise payable to a budget group member diverted by the payor to a third party, unless such payment arrangement is made at the request of a budget group member or the FRR of a budget group member. An example of a legally obligated payment which is excluded: Absent parent contribution paid, either by court order or at the absent parent's discretion, directly to the landlord to cover rental expenses or to a physician or other medical service provider.

- Monies received from a source outside the home designated for the care and maintenance of a person who is neither a budget group member or the FRR of a budget group member.

  NOTE: If a lump sum is received which includes payment for a budget group member and/or a FRR of a budget group member, prorate the total payment to determine each individual's share and consider the budget group member and/or FRR's share as countable income.

- Reimbursements for supporting services and out-of-pocket expenses to volunteers in any of the programs authorized by Titles II and III of the Social Security Act.

- Employer reimbursement of expenses an employee incurs specifically in the performance of his duties for items other than normal living expenses.

  NOTE: The amount by which a reimbursement exceeds the actual incurred expense is countable income.

- Vocational Rehabilitation agency reimbursements to clients for direct program participation costs.

- Student Financial Aid

Exclude that portion of a grant, scholarship or fellowship used to pay tuition, fees or other necessary educational expenses. Exclude as income and resources any educational benefits paid to or in behalf of any budget group member. This includes undergraduate educational grants, loans, scholarships, stipends, and/or college work study payments. This exclusion is also applicable to educational income of the parent of a minor parent and of the stepparent in deeming budgets.

- Exclude in their entirety the following types of undergraduate financial aid:

  - Pell Grant
  - SEOG Grant
  - National Direct Student Loan
  - Guaranteed Student Loan
  - State Student Incentive
  - Any financial aid paid directly to the school and unavailable for use at the student's discretion.
  - College Work Study

- SSA/VA benefits for Students age 18 and older

  Exclude from the SSA or VA benefit paid to a student at least age 18 in an amount equal to the following mandatory costs of education. (The remainder of the SSA or VA benefits is considered part of the student's countable income.)

  - Tuition and mandatory fees
  - Required books and supplies
  - Transportation to and from school limited to 38 cents per mile or costs of public transportation
  - Cost of child care necessary to attend school not to exceed $200 per month per dependent under age 2 and $170 per month per dependents age 2 and above.

- VA Aid and Attendance Allowance

  Exclude any portion of a VA payment that is considered an allowance for aid and attendance in eligibility determination for institutionalized and non-institutionalized individuals and when figuring patient liability for institutionalized individuals.

- VA Contract

  Individuals who are institutionalized under a VA Contract are NOT eligible for TennCare Medicaid or vendor payments while the VA contract is in effect.

- Augmented VA Benefits

  Exclude any portion of a VA benefit which can be verified as earmarked for someone other than the client, i.e. spouse or dependent.

- VA payments resulting from Unusual Medical Expenses

  Exclude these payments in determining eligibility for institutionalized and non-institutionalized individuals and in determining patient liability for institutionalized individuals.

- Agent Orange Settlement payments in determining eligibility

  Exclude Agent Orange Settlement payments in determining eligibility. These payments are budgeted in patient liability determination for institutionalized individuals.

- The $20 General Income disregard

  This disregard is for "Would be SSI Eligibles" Only. Exclude up to $20 per month of all unearned income except that unearned income the individual receives based on his need, e.g., VA pension.

- Self-Support Plan Income

  Exclude unearned income received to fulfill an approved self-support plan provided the individual is blind or disabled.

- Domestic Commercial Transportation Tickets received as gifts

  Exclude the value of any commercial transportation ticket, for travel by such individual or spouse among the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa and the North Mariana Islands, which is received as a gift by such individual or spouse and is not converted to cash.

- Mandatory Deductions

  Exclude mandatory deductions such as FICA and withholding tax on pensions and other unearned income in the eligibility and patient liability determinations for institutionalized cases only.

- Interest on Excluded Burial Funds and Space

  Any interest earned on the value of excluded burial funds and on agreements representing the purchase of an excluded burial space are excluded from income (and resources) if left to accumulate. This income exclusion applies only if the fund or agreement is excluded at the time interest is paid. Appreciation value and interest must be left to accumulate (e.g., paid directly to the individual, spouse, or parent). The receipt of the value or interest may result in countable income.

If such interest is paid on a non-excluded fund or agreement, the interest is treated under interest income policy. When excluded and non-excluded funds or agreements are commingled, only the interest on the excluded portion is excluded. The irregular and infrequent income exclusion is NOT applied to interest earned on excluded burial funds or space agreements.

- German Reparation Payments
- Japanese-American and Aleutian Restitution Payments
- Alaska Native Claims Settlement Act exclusions
- State funds paid to crime victims.
- Payments made to individuals because of their status as victims of Nazi persecutions are to be excluded as income.
- Income paid under PL 104-204 to children born of Vietnam veterans diagnosed with spina bifida.
- Value of food coupons under the Food Stamp Act of 1977 (Pub. L. No. 95-113)
- Value of free or reduced price food for women and children under the Child Nutrition Act of 1966 (PL No. 89-642 and 92-433) and the National School Lunch Act (PL No. 90-302)
- Value of federally donated foods distributed under PL No. 74-320 or section 416 of the Agriculture Act of 1949.
- Low Income Energy Assistance payments provided through the Department of Health and Human Services including that authorized by the Energy Crisis Assistance and Crisis Intervention programs.
- Assistance to prevent full utility cut-offs and to promote energy efficiency under these programs authorized by the Economic Opportunity Act of 1964 (PL No. 63-611 and 95-568):
    - Emergency Energy Conservation Services Program
    - Energy Crisis Assistance Program
- Fuel assistance payments and allowances under the Home Energy Assistance Act of 1980 (PL No. 69-223)
- Value of any assistance paid with respect to a dwelling unit under:

- Housing Authorization Act of 1976
- The National Housing Act
- The Housing & Urban Development Act (sec. 101)
- Title V of the Housing Act of 1949
- Section 202(h) of the Housing Act of 1959
- Any Housing Assistance in which HUD or FMHA is involved (includes subsidized housing, public housing, reduced rent, cash towards utilities; loans for renovation, construction, improvement or replacement of farm homes and other buildings; mortgage or investment insurance; guaranteed loans and mortgages, etc.)

- Relocation payments pursuant to the Uniform Relocation Act (PL No. 61-646) and Title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Acts of 1970 (applies to assistance provided to persons displaced by any Federal or Federally–assisted project and to assistance provided by a State or local government or through a state-assisted or locally-assisted project which is comparable to the Title II mentioned herein) and Real Property Acquisition Policies Act of 1970.

- Grants or loans available to undergraduates under the Higher Education Amendments of 1968 (PL No. 90-575).

- Wages, allowances and attendance care costs paid to employees of project under Title VI of the Rehabilitation Act of 1973 (PL No. 95-602).

- Revenues from the Alaska Native Fund paid under section 21 (a) of the Alaska Native Claims Settlement Act (PL No. 92-203).

- Distribution of perpetual judgment funds to Indian tribes under the following:

  - Indian Judgment Funds, Distribution (PL 93-134)
  - Black Feet and Gros Ventre Tribes (PL No. 92-254)
  - Grand River Band of Ottawah Indiana in Indian Claims Commission Docket No. 40-K (PL No. 94-540).
  - Tribes of groups under Public Law No. 93-134.
  - Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (PL No. 94-433).
  - Receipts from land held in trust by the Federal government and distributed to certain Indian tribes under PL No. 94-114. NOTE: Any local tribal funds that a tribe distributes to individuals on a per capita basis (e.g. gaming revenues) are NOT excluded as income and resources under this provision. SI 0830-830.

Annuities, Pensions, and Other Periodic Payments

An annuity is a type of trust with periodic payments generated by a bank or insurance company from funds deposited by the individual either in a lump sum or installments to establish a source of income for a future period.

This type of unearned income is usually related to prior work or service and is received on a regularly recurring basis, usually monthly.

Use at least one of the following methods to verify the periodic payment amount.

- Individual with a Recent Link to SSI. If the individual is or has recently been a SSI recipient, verification of other types of income is available on the data base as well as the sources described following.

- All other Individuals: matches received for the source on the data base or written verification from the source of the income (e., g., SSA, RRB, VA, etc.) including an award letter.

  NOTE: Include the Veteran's file number with all requests for information to the Veterans Administration.

- Photocopy of the most recent check and verification of direct deposit into the individual's bank account if the source of the deposit is specified AND the date of the deposit is included.

More information on Annuities can be found in the Resources Chapter of this Manual.

Dividends, Interest, and Royalties

Dividends and interest are returns on capital investments such as stocks, bonds, savings accounts including accrued interest on loans made by the client.

Count income received on a monthly basis as unearned in the month the individual receives it or the month it is available for his/her use.

Convert interest payments received on other than a monthly basis to a monthly amount by prorating the payment over the accrued period. For example, divide the value of interest payments paid on a quarterly basis by 3 to determine a monthly amount.

Interest Payments on a Note Held by the Client

If the note held by the client is a countable resource (i.e., the amount of the unpaid principal is an available asset) any interest payment made by the debtor is unearned income to the client. If the unpaid principal on the note is an unavailable asset, (e.g., mortgage or note cannot be sold without a 10% or more discount), payment made by the debtor towards the principal and/or interest are considered unearned income.

Methods of Verification

- Dividends and Interest

Secure copies of dividend reports, bank statements and/or loan payment receipts to determine the amount of dividends/interest paid during the period under consideration.

- Royalties

  Secure verification from the source of royalty income as to the amount and date of payment.

Rental and Farm Income as Unearned Income

Rental Income

Rents are payments for the use of real or personal property such as land, housing or machinery. Rental income is considered unearned when the individual is not a real estate dealer or property owner engaged in the business of buying, selling and/or renting for profit. Rental income is earned income from self-employment when someone is in the business of renting properties.

Count the net rental income in determining income eligibility. Gross income from rent is subject to the following deductions for paid (not unpaid) expen**ses necessary for the production or collection of the income.**

- State and local real property taxes
- General sales taxes
- Interest on debts
- Expenses of managing and maintaining the property
- Mortgage interest and escrow payments
- Real estate insurance
- Fire insurance premiums
- Normal maintenance and repair—minor corrections to an existing structure. If the property was not rented during the previous year, deduct those expenses the individual intends to pay excluding any expenses for which the individual is unable to provide substantiation such as projected repairs.
- Lawn care and snow removal
- Advertising for tenants

These are non-deductive expenses:

- Principal portion of a mortgage payment
- Capital expenditures (i.e., an expense for an addition or increase in the value of property which is subject to depreciation for income tax purposes).

Determining Countable Net if Rents Received on a Regular Basis

1. Determine the amount of gross rents for one year in one of the following ways:
    - Base current year's expected gross rents on the amount received in the immediately preceding year if a change in the amount is not expected.
    - Base current year's rents on a projection of the amount the individual expects to collect, e. g., current rental income/month X 12 = Annual Total.
    - Use gross rents reported on previous year's Federal income tax return.
2. Deduct the allowable expenses incurred and paid during the previous year as listed earlier in this section.
3. Prorate the net annual rental income to determine the amount of countable net income from rents.

    ANNUAL NET RENTS
    ---------- = NET RENT/MONTH
    12 **OR**

    Use annual profit reported on previous year's Federal income tax return.

Determining Rents Received on an Annual or Infrequent Basis

Determine the amount of gross rents using any of the methods described above. Net rental income is determined by deducting the amount of allowable, paid, and substantiated expenses from the gross as listed earlier. The resultant net rental income is counted as unearned income in the month the individual receives it and is not prorated.

It is likely the client will be able to anticipate the month he will receive such annual or infrequent income. The caseworker should set up an Expected Change prior to the month of anticipated receipt to allow for sufficient time to include the income in the individual's budget for that month.

Verification Methods

Use one of the following to verify the amount of rental income:

- Secure a copy of the rental/lease agreement in effect during the period under consideration.

- Secure a statement from the renter indicting the amount of rent and date of payment.
- Secure a copy of the receipt for the client (or his/her agent) prepared upon receiving rental income.

Secure the following verifications for expenses necessary for the production of the rental income.

- Current tax bill or notice of assessment and verification of payment.
- Verification of the amount of the mortgage interest payments.
- Itemized list of other expenses and repairs and substantiation of payment.

Farm Income

Farm income is considered **unearned when the individual does not materially participate in the production of the income** and the income results from an arrangement other than that described in the Earned Income section of this Chapter.

Determining the Gross Amount of Farm Income

Use any of the following methods to determine gross farm income.

- Annual gross reported on the previous year's Federal income tax return.
- Review the individual's records for the previous year to determine gross income.
- If the individual had no farm income during the previous year, base current monthly gross amount on the amount(s) earned during the immediately preceding month(s).

Determining Net Farm Income

Use one of the following methods to determine net farm income.

Gross farm income is subject to the following deductions for expenses necessary for the production or collection of the farm income if they are paid, not simply incurred.

- State and local real/personal taxes
- Expenses
- Mortgage interest payments

- Fire insurance premiums
- Farm expenses for which the client is responsible, e.g., fertilizer, equipment, etc.; or
- Use the annual profit reported on the previous year's Federal income tax return.

Counting Net Farm Income

If the unearned farm income is received on a regular basis, i.e. at least monthly, prorate the annual net to determine the amount to be counted each month in determining income eligibility.

The formulas for determining monthly net are:

ANNUAL GROSS
-EXPENSES FOR ONE YEAR
ANNUAL NET

$$\frac{\text{ANNUAL NET}}{12} = \text{MONTHLY NET}$$

If the farm income is received on an annual or infrequent basis, do not prorate the annual income. Count the net income in the month the individual receives it.

The client should be able to anticipate the month in which he expects to receive such annual or infrequent income as in the case of a farm allotment. The caseworker should set up an Expected Change prior to the month of anticipated receipt to allow sufficient time to include this income in the individual's budget.

Verification Methods

Use any of the following methods of verification as appropriate:

- Secure a copy of the rental/lease agreement executed by the client and the individual working the farm.
- Secure a copy of the most recent profit/loss statement.
- Secure verification such as bills, assessment notices, itemized statement of purchases, etc., required to substantiate the individual's expenses.

Proceeds of Life Insurance

All payments the individual receives as the beneficiary of a life insurance policy are proceeds of life insurance and are considered unearned income in the month of receipt.

A portion of the proceeds of life insurance may be disregarded if the client paid last illness medical expenses and/or burial expenses for the deceased. Disregard the smaller of the following and count the remainder as unearned income in the month received:

- The amount paid for medical expenses related to the last illness and/or burial expenses, OR
- The amount of the death benefit itself.

Verification Methods

Use one of the following methods to verify the amount of the new life insurance proceeds.

- Secure a statement from the life insurance company indicating the amount and date of payment to the client.
- Review correspondence from the company and photocopy the proceeds check (if possible).

To verify the last expenses, secure copies of all pertinent medical and/or burial expenses and substantiation that the client paid them.

Prizes and Awards

The value of a prize or award is unearned income in the month the individual receives it.

A prize is something won in a contest, lottery or game of chance. If the individual is offered a choice between an in-kind prize or cash, the cash offered is counted as unearned income even if the individual chooses the in-kind item and regardless of the value, if any, of the in–kind item.

An award is received as the result of a decision by a court, board of arbitration, etc. Secure from the client whatever verification he/she has available including any of the items in the following list:

- Award letter
- Copy of the check
- Contest advertisement
- Income tax return for the year prize/award claimed

Gifts

A gift, as countable income, is limited to cash received by a Budget Group member without the giver's legal obligation or as repayment for goods or services. The value of a gift, either cash or in-kind, the individual receives is counted as unearned income in the month of receipt. The value of cash gifts is counted in whole in the month of receipt, unless it can be excluded as infrequent and irregular income.

The value of in-kind gifts is equal to the value of the item on the open market, i.e., current market value. The gift's value is unearned income unless it can be excluded as infrequent or irregular income.

A gift of a house which is used as shelter is not counted as income and is exempted as a homestead (except in the Pickle and Pass along categories where it is valued as a resource under Presumed Maximum Value rule). A gift of a house which is not used as shelter is not counted as income and is valued as a resource at its current market value.

Gifts of commercial travel tickets for domestic travel are excluded from income if they are not converted to cash.

Death benefits, including gifts, are not income in the month of receipt. This does not include a cash gift as mentioned above.

Verification Methods

Use any of the following methods to verify the type, amount and date of receipt of a gift:

- Photocopy of the check.
- A written or verbal statement from the donor regarding the gift's value and date given.
- In the absence of either (1) and (2) above use the client's sworn statement.

Inheritance

An inheritance is cash, real or personal property or use rights to real/personal property available to the client as the result of someone's death.

Until an item or right has a value (i.e., can be used to meet the heir's need for food, clothing or shelter), it is neither income nor a resource. An inheritance is not income to an individual if the inheritance is something that was considered that individual's resource immediately before the death, i.e., the proceeds of a life insurance policy were not a resource before the death.

The value of inherited cash is counted as income in the month of receipt and if the individual retains it, as a resource in the months thereafter. The month of receipt for an inheritance composed of cash is the month the individual receives the money.

The value of resource items such as personal/real property (or use rights) is countable in the month of receipt, and continues to be counted as long as it is retained. The month of receipt for resource items such as real or personal property (or use rights) is the month the will specifying the individual's inheritance went into Probate. During the Probate period, the inherited item(s) are considered countable assets because they could be sold.

Refer to the chapter on Resources for further details regarding counting the value of inherited resources.

The inheritance of a house used as shelter for the individual is not counted as income and is exempted as a homestead except in Pickle, Pass Along categories where it is valued as a resource under the Presumed Maximum Value rule.

Death benefits, including inheritance, are not income in the month of receipt. This does not include a cash inheritance as mentioned above.

Verification Methods

Secure one of the following items to verify the individual's allegations regarding his inheritance.

- Copy of the Will
- Statement of the Probate Court
- Statement from an attorney involved in the case

Death Benefits

A death benefit is received as the result of another's death. Examples of death benefits include:

- Proceeds of life insurance policies received due to the death of the insured;
- SSA, VA or Railroad Retirement lump sum death benefits;
- Inheritances in cash or in–kind;
- Cash or in–kind gifts given by relatives, friends or a community group to "help out" with expenses related to the death, etc.
- NOTE: Recurring survivor benefits such as received under SS Title II, private pension programs, etc. are not death benefits.

Death benefits are income to an individual if the total amount exceeds the expense of the deceased person's last illness and burial paid by the individual to whom the death benefit is issued. Last illness and burial expenses include:

- Related hospital and medical expenses
- Funeral, burial plot and interment expenses
- Other related expenses

Deemed Income

Income considered available to any member of the Budget Group from a financially responsible relative (FRR) is deemed income. **Do not deem income from a FRR who receives any type of Public Assistance, i.e. Families First or SSI.**

If the individual has a spouse, deem income from his/her FRR (spouse) during the period he shares a living arrangement in the community with his spouse. They are not considered as sharing a living arrangement if both are institutionalized in the same or separate rooms, unless one spouse is enrolled in HCBS in the home.

Under Spousal Impoverishment provisions, the Community Spouse (CS) is considered as an individual if the CS applies for TennCare Medicaid during the month of his/her spouse's admission to a long-term care facility. None of the Institutionalized Spouse (IS)'s income and resources is considered in determining the CS's eligibility, except the income which is allocated during spousal allocation policy application.

NOTE: The individual in HCBS in the home is considered institutionalized in determining his/her TennCare Medicaid eligibility. However, TennCare Medicaid eligibility for the CS is determined using deemed income and resources from the HCBS spouse.

Deemed income is counted as unearned income in the month of receipt. If deemed income is earned, apply the standard work expense to the earnings prior to deeming the income to the dependent(s).

Methods of Verification

Verify the source and amount of the FRR's income based on the type (earned or unearned) as described in the appropriate sections of this Chapter.

Contributions

Count regular contributions made directly to the individual as unearned income unless they can be excluded as irregular or infrequent income.

Secure a written or verbal statement from the party making the contribution as to its amount and frequency of payment.

NOTE: Exclude income considered casual and inconsequential income. Casual and inconsequential income is monetary gifts/contributions (e.g., Christmas, graduation, birthday gifts) that do not exceed a total of $30 per recipient per calendar quarter.

The Medicare Catastrophic Coverage Act of 1988 provided a more liberal treatment of the income of the institutionalized individual who has a spouse living at home, i.e., the community spouse Refer to the Chapter in this Manual on Budgeting for Institutionalized Individuals.

Alimony or Support Payments

Alimony is counted as unearned income in the month of receipt.

The value of support payments is counted in its entirety for individuals age 21 or older as unearned income in the month of receipt. Exclude up to $50 per month per family of absent parent support payments received for the child under age 21. The remaining value is counted as unearned income in the month of receipt. If support is paid out of a benefit (e.g. VA, SSA, etc.), it does not retain its benefit status. The Child Support exclusion of $50 is deducted. However, if the benefit is paid directly to the child or to a representative payee who turns it over to the court, it is not considered Child Support.

Exclude one-third of the value of absent parent support payments received by an institutionalized individual under age 18. The remaining two-thirds value is counted as unearned income in the month of receipt.

Use one of the following methods to verify the value and frequency of payments of support/alimony payments:

- Review the agreement awarding the individual alimony/support payments.
- Secure a written statement from the individual paying the support and a photocopy of a recent alimony/support check or receipt the client prepared if the individual is paid in cash.
- Contact with the court clerk for support paid through that office.

Sick or Disability Payments

Sick or disability payments made by an employer 6 months or more after the last month the individual worked are considered unearned income in the month of receipt.

Verify the amount and date of receipt of these payments using one of the following methods.

- Secure recent check stubs.
- Secure a written statement from the employer or insurer indicating the amount of the payment, date paid, and related information concerning continued payments.

Payments Received On an Unavailable Asset

If the individual holds a note or mortgage the principal of which has been determined to be an unavailable asset, any payments made by the debtor towards principal and/or interest are considered the individual's unearned income.

Verify the amount and frequency of payments by reviewing the terms of the loan agreement or by securing the debtor's written statement regarding his repayment.

Care and Support Contributions Provided In Exchange For a Transferred Asset

If the individual has transferred an asset and part or all of the compensation he received included a provision for lifetime total care and support, the value of the care and support contribution is unearned income.

Determining the Value of the Contribution

The amount of the care and support contribution is based on the payment ability of the recipient of the transferred asset. Determine the monthly amount of the care and support contribution in the following way:

- Determine the monthly gross income of the individual to whom the asset was transferred. If the income is earned, subtract the following work and related expenses:

    - Federal/State withholding taxes
    - Social Security taxes
    - Contributions to a retirement fund over which the individual has no control
    - Child care expenses incurred as a result of employment
    - Union dues
    - Transportation costs limited to the actual cost of public or car pool expenses or 42 cents/mile
    - Health insurance premiums for self and dependents for which he/she is financially responsible.

- The result is the net earned income.

- Combine the net earned income with the individual's monthly gross unearned income. Subtract the following two items from the resultant total to determine the amount of the care and support contribution.

    - The amount of the Medically Needy Income Standard (MNIS) appropriate for a group of individuals that includes: the recipient of the transferred asset, the number of individuals living in his household for whom he is financially responsible; **AND** the applicant/recipient.

- Fifty per cent (50%) of the appropriate MNIS used in the previous calculation. The result is the amount available to the client as a care and support contribution each month.

Counting the Value as available income

A contribution is considered unearned income available to the individual indefinitely. The amount is affected by any changes in the financial situation of the recipient of the transferred asset.

Re-evaluate the amount of the contribution at every re-determination and more frequently if necessary.

Methods of Verification

Verify the gross (and net earnings) of the individual to whom the asset was transferred using any of the methods appropriate to the type of income as described in this Chapter.

Unemployment Compensation, Worker's Compensation and Strike Benefits

Unemployment Compensation

Count the full value of Unemployment Compensation benefits as available unearned income in the month of receipt.

Obtain written verification of UIC benefits from one of the following.

- Written verification from TN Department of Labor; **OR**
- Verification through the TN Clearinghouse System; **OR**
- Access through Data Matches found on the data base.
- Written verification from state of issue if UIC is from another state.

Worker's Compensation

Worker's Compensation is paid to a permanently or temporarily disabled worker by his/her employer or the employer's insurance company. In addition to a cash payment, usually some percentage of the disabled worker's salary, the individual may also be entitled to third party medical support either through continued coverage from the employer's insurance plan or through a special fund set aside for injured workers. Review possible third party support for every individual receiving Worker's Compensation benefits.

Count the gross amount of all benefits the individual receives as unearned income in the month of receipt.

Secure written verification of the amount of Worker's Compensation payments and their frequency from the individual's employer or the payer of the benefits.

Strike Benefits

Any parent on strike on the last day of a month results in ineligibility for that parent and all of his/her children. Any other individual on strike on the last day of the month is ineligible. This does not apply to pregnant women.

Treat strike benefits as any other type of unearned income and consider it available in the month in which it is received.

Secure written verification of the amount of payment(s) and their frequency from the union or payer of the benefits.

Trust Fund Proceeds

Money withdrawn from the body of a trust or interest/dividends accrued to the trust and subsequently paid to the individual are unearned income in the month of receipt.

If the money is received on other than a monthly basis, prorate it over the period of time it is intended to cover. If payment is made in a lump sum and is not expected to recur, treat the payment as a one-time lump sum.

The caretaker of a child for whom a trust of $5000 or less has been established is not required to petition the court to make the trust available. The legal fees involved in such an attempt would, in most instances, reduce the value of the trust to the extent that it would not be cost effective for the individual(s) or the department.

Secure written verification of the amount of the trust proceeds and frequency of payment from the trustee or the financial institution holding the trust.

Rehabilitation Payments

Count payments for rehabilitation made under Services to the Blind, Vocational Rehabilitation (VR), or other such programs as unearned income.

Deduct the costs of expenses (specified by the rehabilitation agency) from the gross amount of the rehabilitation payment used by a client for expenses required to participate in the rehabilitation program. The expenses are usually designated by the VR agency and include, but are not limited to, the following:

- transportation costs to and from the training facility, doctor, clinic, etc. based on the current state mileage rate or public transportation;
- books, tools, equipment, etc. not furnished by the facility;
- supplies such as pens, pencils, notebooks, etc. not furnished by the facility;

- required occupational clothing (e.g., uniforms, inclement weather gear, etc.);
- noon meals (not to exceed $3.00) if purchased at the training facility or in restaurants during the training day;
- laundry and cleaning expenses related to training;
- incidental expenses over and above "personal incidentals" such as coffee breaks, grooming aids, some recreation (not to exceed $30.00 per month) if the person is away from home; AND
- initial outlay items (e.g., footlocker, suitcase) not furnished by VR or Services to the Blind when the training facility is located in a different town.
- Count any remaining rehabilitation payment as unearned income.

NOTE: Costs for items not included in our need standard, but necessary to participate in the rehabilitation program can be excluded as assistance from other agencies.

Department Of Veterans Affairs Payments

The Department of Veterans Affairs (VA) has numerous programs which make payments to individuals and/or their families. Treatment of these VA payments depends on the nature of the payment.

Potentially eligible VA recipients may be:

- A veteran
- The child or spouse of a disabled or deceased service person or veteran.
- The unmarried widow/widower of a deceased service person or veteran.
- The parent of a service person who died before January 1, 1997 from a service connected cause.

The VA Regional Office for Tennessee is located at 110 Ninth Ave. South, Nashville, TN 37203.

The most common types of VA payments are:

- Pensions

  VA pension payments are made on the basis of a combination of service and an age of 65 or over or a non-service connected disability or death. VA pension payments are usually based on need.

The VA may take dependents' needs into account in determining a pension. However, normally the VA will not make a pension payment directly to a dependent during the lifetime of the veteran. Instead, the amount of the veteran's basic pension is increased if the veteran has dependents. A VA pension payment that has been increased for dependents is called an augmented VA payment. A VA pension payment made directly to the dependent of a living veteran is called an apportioned payment.

VA pension payments are usually made on a monthly basis. However, when the payment due is small the VA will pay quarterly, biannually, or annually. The VA may also make an extra payment if an underpayment is due.

VA Pension **Not** Subject to $20.00 Disregard. Most VA pension payments are federally funded income based on need. As such, the $20.00 general income disregard does not apply.

VA Pensions **Subject** to the $20.00 Disregard. However, the following pensions paid to veterans or their dependents are not needs based unearned income. Therefore, the $20.00 general income disregard does apply to these payments which are made on the basis of:

- a special act of Congress;
- service in the Indian Wars (January 8, 1817 through December 31, 1881);
- service in the Civil War (1861 through 1865); or
- service in the Spanish-American War (April 21, 1898 through July 4, 1902)

VA payments made less frequently than monthly (e.g., quarterly, biannually ,etc.) are income in the month the payment is received.

Assume that a VA pension is needs-based unless there is an indication that the pension is one of those listed above. Use an award letter or other document in the individual's possession to verify the payee and the gross amount of the payment. Use documents in the individual's possession to verify frequency of the payment. If these do not provide information, accept an individual's signed allegation of the frequency.

- Compensation

When a VA decision is based on need, it is not considered income for purposes of Medicaid/TennCare eligibility.

VA compensation payments are made on the basis of a service-connected disability or death. Dependents for purposes of compensation include certain dependent parents. Payments to dependent parents are made on the basis of a service-connected death only.

A living veteran's compensation payment may be increased (augmented) for dependents. In unusual circumstances, a VA compensation payment may be made directly to the dependent of a living veteran (apportioned).

Compensation payments are unearned income for TennCare Medicaid purposes.

- Augmented and/or Apportioned VA Benefits

  In some instances, the VA considers the number of dependents a veteran has in determining the amount of the veteran's or widow(er)'s benefit. Benefits which are increased because of dependents in VA or SSA records does not necessarily mean a payment will be augmented. VA benefits which may be augmented are pensions, compensation, and educational assistance. When a benefit is augmented, the augmentation (i.e., increase for the dependent) may be included in the payment to the veteran or widow(er), or a payment may be made by apportionment (i.e., separate check to the dependent).

  Count as income to the individual only that portion of a VA benefit attributable to the veteran or widow(er) as income to him or her.

  The amount by which a VA benefit is augmented because of a dependent is income to the dependent. The augmentation which is income to a child is not child support.

  EXCEPTION: Augmentation is not income to the dependent on whose behalf it is paid provided the dependent:

  - lives apart from the veteran/surviving spouse, and
  - has applied to the VA for apportionment; and
  - has received the VA's written denial of the apportionment request; and
  - has not received the augmentation directly from the veteran/surviving spouse.

  In the event that all of the conditions above do NOT exist, the augmented amount is income to the dependent. If **all** of the conditions above exist, the augmentation amount for that dependent is income to the veteran or surviving spouse the month after the month in which the VA denial notice is dated. At that point, the dependent does not have income in the form of VA augmentation. However, if the dependent returns to the household of the veteran or surviving spouse, attribute the augmented portion to the dependent effective the month following the month of the move.

Treatment of VA Pensions for Residents in Tennessee State Veterans Homes (Veterans Health Improvement Act of 2004 (HIPA)

On November 30, 2004 the President signed into law the VIHPA of 2004. This act prevents Medicaid from offsetting the VA "per diem" payment. The veteran's administration pays states a per diem payment for nursing home care. Prior to the enactment of the VHIPA these payments were considered a third party resource under Medicaid laws and were used to offset

the Medicaid payment to these nursing homes. Effective November 30, 2004, these payments are no longer considered, therefore income received based on VA A&A is excluded from consideration in Medicaid cases including residents of the State Veteran Home.

Educational Benefits

The VA provides educational assistance under a number of different programs including vocational rehabilitation. Depending on the nature of the VA program, different SSI income and resource policies apply.

Generally, veterans have 10 years after leaving the service to complete their education and 12 years to complete a program of vocational rehabilitation. Payments are usually made on a monthly basis only for months in which the veteran is in school. However, if school attendance is less than half time, the payments may be made less frequently. Dependents and survivors of veterans may also be eligible for educational benefits.

Some programs are "contributory". That is, the money in the fund is contributed to an educational fund and the government matches the money when it is withdrawn while the veteran is pursuing an education. The veteran has the right to withdraw as a lump sum the funds he has contributed.

Types of Programs:

- Veterans Educational Assistance Program (VEAP) is a program under which education benefits are paid to veterans who entered active service between January 1, 1977 and June 30, 1985. This is a contributory program. Under VEAP, the veteran has the right to withdraw his contributions in one lump sum at any time. However, if he does so, the government will not match his contributions. Payments under VEAP are not augmented for dependents.

- The new GI bill—Active Duty Educational Assistance Program is a program under which educational benefits are paid to veterans who entered active service on or after July 1, 1985, and to veterans with service between February 1, 1955 and December 31, 1976 and certain veterans who entered active duty in 1977 who served 3 years after July 1, 1985. During active service, the military pay of an individual electing to participate in this program will have been reduced for 12 months; however, this is not a contributory program. Payments under this program are not augmented for dependents if the veteran entered service on or after July 1, 1985.

- The "new" GI bill—Selected Reserve Program is a program under which a reservist with a 6-year commitment may receive educational assistance while in the reserves. This is not a contributory program and the payments are not augmented for dependents.

Treatment of VA Educational Benefits

Any VA educational benefit payment or portion of such a payment, which is funded by the government, and is not part of a program of vocational rehabilitation is unearned income for SSI purposes.

Payments made as a part of a VA program of vocational rehabilitation are not income. Subsistence allowances received during vocational rehabilitation may be augmented, but the augmentation is not income.

Only that portion of an educational payment which is income to the individual obtaining the education is subject to the exclusion for educational expenses. The augmented portion which is income to the dependent is not subject to this exclusion for educational expenses.

The $20.00 general income disregard applies to educational assistance, and the payments are subject to deeming.

Verification of Benefits

Use award letters or other documents in the individual's possession to verify the type and amount of educational benefits. Verify the frequency of payment unless the DHS caseworker is familiar with the frequency of a particular type of payment through experience or precedent, in which case the individual's allegation is sufficient.

If there is evidence on file that the veteran's active services began prior to January 1, 1977 or that the veteran first entered active service on or after July 1, 1985, assume that the educational benefits are paid under a noncontributory program.

A signed allegation is sufficient evidence of service dates. If there is evidence that the veteran's active service began between January 1, 1977 and June 30, 1985, assume that the educational benefits are paid under a contributory program.

If payments are made under a contributory program or the nature of the program is in question, obtain evidence of the following:

- The amount of the veteran's contributions remaining in the fund that can be withdrawn as a lump sum.

- The portion of any VA educational benefit payment that is a withdrawal of the veteran's contributions to the fund. To verify this information with the VA, request the information in the following manner: "As of (insert date), please provide the dollar amount of the veteran's contributions to the education fund which the veteran is (was) entitled to withdraw as a lump sum without attending school. For each periodic payment of educational benefits, please provide the dollar amount representing the veteran's contribution."

Aid and Attendance and/or Household Allowances

The VA pays an allowance to veterans, spouses of disabled veterans and surviving spouses who are in regular need of the aid and attendance of another person or are housebound. This allowance will be combined with the individual's pension or compensation payment.

Aid and attendance or household allowances are not income in determining an individual's eligibility whether institutionalized or non-institutionalized. It is also not counted when authorizing Medicaid/TennCare vendor payments (determining patient liability) to the individual confined to a Long-Term Care Facility or enrolled in HCBS.

When the individual who receives an allowance pays someone else to provide services, that payment is income (earned or unearned) to the person providing the services—unless that individual is a person from whom income is deemed to the original recipient of the allowance. The amount charged as income is the payment actually made for the services. Do not assume that a veteran who receives an allowance makes a payment to an eligible spouse who takes care of him.

Verify the amount of a pension or compensation payment whenever:

- An aid an attendance or housebound allowance is alleged, or

- A veteran, spouse of a disabled veteran, or surviving spouse is housebound, blind, unable to dress or care for self, or a patient in a nursing home, or single and severely and permanently disabled, or otherwise appears to require the assistance of someone else on a day-to-day basis.

A VA check or award letter is not reliable verification of the amount of income if an aid and attendance or housebound allowance is involved. When the VA provides the amount of the pension or compensation payment verification, they will not include a housebound or aid and attendance allowance. The aid and attendance or housebound must be verified separately.

Clothing Allowance

A lump sum clothing allowance is payable in August of each year to a veteran with a service-connected disability for which a prosthetic or orthopedic appliance (including a wheelchair) is used. The allowance is intended to help defray the increased cost of clothing due to wear and tear caused by the use of such appliances.

A VA clothing allowance related to use of a prosthetic or orthopedic appliance is not income in eligibility determination or patient liability computation.

Accept the individual's allegation concerning a VA clothing allowance received by a veteran who uses a prosthetic or orthopedic appliance. No further development is required.

Payment Adjustment for Unusual Medical Expenses (UME)

Unusual medical expenses are non-reimbursable medical expenditures that exceed 5% of the applicable maximum annual VA payment rate. The reimbursement for these medical expenses may result in a higher monthly VA payment, an extra payment or an increase in a payment.

Exclude the amount of any VA payment identified as being received due to unusual medical expenses when determining an individual's income eligibility.

For institutionalized individuals in the post-eligibility determination of patient liability, these VA payments resulting from unusual medical expenses are also excluded.

Insurance Payments

Payments may be made by VA for disability insurance and/or life insurance. Verification may be made from the individual's proof of VA insurance or from a VA regional office.

Lump Sum Income

A lump sum is a one-time payment, usually for retroactive benefits such as, Social Security, Workmen's Compensation, or Veterans benefits. Also, a surviving spouse may receive a lump sum death benefit from the SSA or some other type of death benefit.

Like other income, lump sum income is counted as income in the month it is received. Lump sums from retroactive SSI benefits are excluded as income in the month received; however, retroactive Social Security benefits are counted as income for the month of receipt. The remainder of the lump sum is considered a resource in subsequent months. More information is available in the Resources Chapter of this Manual.

If the individual receives an advance Award Notice of Lump Sum benefits, budget the sum as income effective the month of receipt.

If the individual reports receipt of a lump sum in a current month, it cannot be budgeted in the month of receipt. Prepare a TennCare Medicaid Report of Over/Underpayment if including the uncounted income results in the individual's ineligibility or an increase in his/her patient liability.

Count the entire amount of the lump sum as unearned income unless one of the following applies:

- Part of the lump sum includes the Social Security death benefit and the client had burial and/or medical expenses to pay for the deceased. Refer to the section "Proceeds of Life Insurance" in this Chapter.

- The client had no income during the retro period and he was eligible for TennCare Medicaid vendor payments. Deduct the PNA (personal needs allowance) for each month of this period during which the individual had no income from the lump sum. Count the remainder as income in the month of receipt. If counting the income results in the individual's ineligibility or an increase in his patient liability for that month, report this as a TennCare Medicaid overpayment.

TREATMENT OF INCOME

Policy Statement

This chapter outlines treatment of income as it relates to the determination of countable income, including deeming methodology, calculations of Categorically Needy and Medically Needy income eligibility, Spend down budgeting, and Institutionalized Individuals budgeting including Spousal Allocation.

Countable income is the income considered available to meet the individual's needs after the exclusion of certain types of income as specified by Federal laws including those exclusions set forth in the Social Security Act. (Exclusions are detailed in the Income Chapter of this Manual).

Income Standards

Each category of coverage has specific income standards to be used in determining income eligibility. Income standards may be found by accessing the DHS Intranet web site at www.intranet.state.tn.us/dhs/desk-guide.pdf. They are also located on various tables in the system.

The Categories of Families First related-assistance, AFDC-MO, MA P and MA S, use the Families First income eligibility standards. The categories of Medically Needy (MN) assistance, currently MA T for pregnant adults and children to age 21, apply the MN income eligibility standards. The SSI-related eligibility categories of Pass Along/Pickle apply the Federal Benefit Rate used by the SSI program as the income standard. The categories which base income eligibility on the Poverty Level Income Standards issued by the Federal government, such as, poverty level pregnant women, children of specified age, QMB, SLMB, QI, and QWDI, use the PLIS income eligibility limits.

Each category of assistance has a Chapter in this Manual that contains more information concerning specifics of eligibility for that category of assistance.

Converting Income to a Monthly Amount

Eligibility determination is done on a monthly basis; therefore, income must be converted to a monthly amount. The following formulas should be used:

- Hourly or piece Work. Multiply the hourly wage by the number of hours the individual worked or is expected to work in a week to determine the weekly earnings figure. Convert the weekly figure to a monthly figure; OR

- Determine the number of pieces an individual averages per day and determine the number of days per week. Multiply these two figures to determine a weekly figure. Convert the weekly figure to a monthly figure as described following.

  - Weekly Income

    Multiply weekly income by 4.3 to determine monthly income.

  - Bi-Weekly Income

    Multiply the amount received every two weeks by 2.15 to determine the monthly amount.

  - Semi-Monthly Income

    Add the two semi-monthly amounts together to determine the monthly amount.

  - Annual Income

    Divide the full amount of annual income by 12 to determine the average monthly amount.

Whose Income to Count In The Budget Group (Cfr-42 435.602)

The available income of the following individuals is considered part of the budget group's countable income.

- Income of the Financially Responsible Relative(s).

  Income belonging to the individual's in-home financially responsible relative is part of the budget group's countable income. **Exception**: the income of an SSI, FF, or VA Pension recipient is not considered available.

- Child's Income

  Countable income belonging to the eligible child (under 21) who is included in the Budget Group is considered in its entirety exclusive of any disregarded amount(s). Do not include in the Budget Group, a child (and his/her individual income) who is an SSI or Families First (FF) recipient.

  NOTE: Income of a TennCare Medicaid BG member used to determine grant amount for FF (such as a stepparent situation) is excluded for the TennCare Medicaid budget group.

  Income belonging to a child (individual under age 21) in his/her own right including income specifically designated for him such as Social

Security benefits or child support, is considered available solely to the child and is not deemed to any other individual unless the child is also a parent. If the child is a parent, the rule of financial responsibility applies.

In Categorically Needy cases, the child with countable income equal to or less than the Consolidated Needs Standard (CNS) for one may elect exclusion from the Budget Group.

NOTE: The BG does not have to contain an eligible child in order for the caretaker to be eligible if the child is under age 21 and parental deprivation exists. The child's income is not deemed to the caretaker relative.

NOTE: As of April 29, 2005, non-pregnant adults age 21 and older no longer qualify in the Medically Needy program.

- Income Belonging to a Caretaker Relative

  Income belonging to a caretaker relative who is not a financially responsible relative is not considered to be part of the Budget Group's countable income unless the caretaker relative requests inclusion in the Budget Group and he/she is otherwise eligible. The caretaker relative who is an SSI or FF recipient does not have the Budget Group inclusion option. NOTE: As of April 29, 2005, non-pregnant adults age 21 and older no longer qualify in the Medically Needy program.

- Income Belonging to a Stepparent/(Major) Parent

  Income belonging to a stepparent/(major) parent is considered when determining the needs of a caretaker relative or optional individual who elects inclusion in the BG. This income is deemed solely to the caretaker relative or individual and is not available to the parent's child(ren)/or other BG members.

  EXCEPTION: Do not deem from a recipient receiving a VA pension, FF or SSI.

  NOTE: As of April 29, 2005, non-pregnant adults age 21 and older no longer qualify in the Medically Needy program.

  ** Information concerning Deeming Income from Stepparents and Major Parents is included in the Medically Needy section of this Chapter.

Whose Income Not to Count in the Budget Group

Explore income available to all members of the household in which the eligible individual resides. Financial responsibility is, however, limited to the legal parent for

his/her child(ren) and from spouse to spouse. It does not include any of the following individuals, although their contributions are considered countable income to the Budget Group (BG):

- The financial assets of any SSI or FF recipient, including a legal parent, are not considered available to members of the Budget Group.

- Income belonging to a relative caretaker other than a parent is not considered available to members of the Budget Group unless the relative has requested inclusion in the BG and is otherwise eligible.

  NOTE: As of April 29, 2005, non-pregnant adults age 21 and older no longer qualify in the Medically Needy program.

- Income belonging to any household members unrelated to the members of the Budget Group is unavailable to the group.

  NOTE: The income of a child's stepparent is unavailable to the child. A remarried caretaker relative who is pregnant or under age 21 who elects inclusion in the BG may have income deemed to him/her from his/her spouse.

  NOTE: As of April 29, 2005, non-pregnant adults age 21 and older no longer qualify in the Medically Needy program.

- The financial assets of any individual including a legal parent, living permanently outside the household are not available to the BG.

- Income belonging exclusively to the child excluded from the Budget Group, including those who exercise their exclusion option, is not available to members of the Budget Group unless the child is a parent or spouse of a BG member.

- The income of a recipient of a VA pension based on need is not included in the Budget Group income unless the recipient's needs are included.

BUDGETING FOR CATEGORICALLY NEEDY GROUPS

Determining income eligibility requires defining the budget group (BG) (who is included), applying appropriate income exclusions, and comparing the gross countable income to the income standard for that category and the budget group size.

Aid Group (AG) refers to the individuals who meet all technical requirements and are eligible for benefits. Individuals may be required to be included in the BG but do not qualify technically for TennCare Medicaid coverage in the AG.

This section details budget procedures for the Categorically Eligible categories of TennCare Medicaid eligibility. Any budgeting requirements for Categorically Needy categories not included here are thoroughly detailed in the Chapter in the manual pertaining to that category.

Budgeting Procedures for Pregnant Women (MA P), MA S Eligible for Families First Except for Sibling Income, and AFDC-MO

MAP is available to pregnant women who do not qualify for Medicaid in any other category but would qualify for Families First/TANF if other children were in the home.

MA S is available to budget groups that would qualify for Families First except for sibling income.

AFDC-MO, also called 1931 Coverage, is available to individuals who are ineligible for Families First because of a requirement that does not apply in Medicaid.

- In determining income eligibility for these categories, the BG is composed of the following individuals:
    - the child or children for whom assistance is requested.
    - the siblings of the child(ren) for whom assistance is requested.
    - the parent(s) of the above named child(ren).
    - no parent is in the home or the parent in the home is incapacitated or unemployed or the child in the BG is deprived of parental support because of absence or death of a parent.
    - the pregnant woman with no other children in the MA P category.
- The deprived child's needs and income may be excluded in the Budget Group for the pregnant or under age 21 Caretaker Relative requesting TennCare Medicaid when:
    - TennCare Medicaid has not been requested for the child.
    - The child is TennCare Medicaid eligible in another budget group (i.e., SSI, MA J, MA N).
- Exclude any child with gross countable income greater than the Consolidated Need Standard (CNS) unless that child is the only child for whom assistance is requested or assistance is specifically requested for that child.

- If the child with income greater than the CNS is the only child for whom assistance is requested, deny benefits due to income in excess of the applicable income standard. Determine eligibility in a Medically Needy group.

- Determine the amount of countable gross income for remaining members of the Budget Group.

- All unearned income, including unemployment compensation, after all applicable disregards have been applied, is subtracted from the CNS in determining eligibility for AFDC-MO.

- Compare the gross income to the Gross Income Standard (GIS) appropriate for the number of persons in the BG.

- Deduct the following from individual earnings of BG members if not excluded prior to the GIS test.

    - The earnings of a full-time student or JTPA earnings of a child after the expiration of the first 6-months-per-calendar-year limit exclusion.

    - The earnings of a part-time student who is not employed full-time.

- Deduct the following from individual earnings of BG members:

    - Dependent care expenses are not to exceed $175 month per dependent over the age of 2, and $200 month per dependent under age 2.

- Combine gross unearned income and net earnings of all BG members.

- Compare the total net income to the CNS appropriate to the number of persons in the budget group. If the total net income is equal to or less than the CNS, the Aid Group is income-eligible. If the AG satisfies all other technical and financial requirements, authorize TennCare Medicaid benefits for Aid Group members only. If income is greater than the CNS and Aid Group is ineligible solely due to a child's income and other eligible siblings are included, the Aid Group may be authorized TennCare Medicaid benefits as Categorically Needy, MA S. If the total net income is greater than the CNS, the Aid Group is ineligible as Categorically Needy because the net countable income exceeds the applicable income standard. Determine eligibility as Medically Needy.

Budgeting Procedures for MA J: Pregnant Women (PLIS), MA J: Certain Children of a Specified Age, Pregnant Women and Infants to Age One, Certain Children of a Specified Age

MA J: Pregnant Woman (PLIS) and MA J: Certain Children of a Specified Age

Pregnant women and certain children of a specified age (to age 19) whose family gross income does not exceed the Federal Poverty Level Income Standard (PLIS).

Pregnant Women and Infants to Age One

The pregnant woman and/or infant to age one are the only eligible individuals. Their eligibility is based on a specific percentage of the poverty level for the family size. Include in the BG, the needs and income of:

- The pregnant woman
- The infant to age one
- The unborn(s) when medically verified that there is more than one fetus
- The pregnant woman's spouse if living in the home
- The pregnant woman's other children living in the home (whole, half and step-siblings to the unborn(s)) whose income does not negatively affect the pregnant woman's eligibility.

  NOTE: After approval of a pregnant woman in the PLIS category, the woman remains eligible regardless of increase in income.

When budgeting families with children of various ages that require the use of different percentages of the PLIS (100%, 133%, 185%), separate budgets may be calculated leaving out one or more children whose income may adversely affect eligibility. The parents (if present in the home) must be included in each budget group.

Certain Children of a Specified Age

Eligibility for a child over age one under a specific percentage of the poverty level is determined based on family size and income. However, the child within the specified age limit is the only eligible individual.

Include in the BG the income and needs of:

- The child(ren) of the specified age limit AND
- His/her parent(s) living in the home, AND

- The child's sibling(s) who do not have sufficient income to cause the child's ineligibility.

  NOTE: There is no deeming for this coverage group. TennCare Medicaid eligibility for other family members who are not pregnant or a child not within the specified age limit must be determined as categorically needy under Families First or other categorical coverage groups, such as, Pickle, Pass Along, and for pregnant adults and children under age 21, Medically Needy.

- For all MA J categories, exclude from the BG any individual and his income who receives Families First cash assistance or SSI payments.

- Do not count the FRR's income from VA needs-based pensions or other income used to determine the amount of the pension.

- Combine individual total gross countable income received in the month of application of all BG members. Count only the pro rata share of the income of the pregnant woman's spouse if they were married during the application-processing period.

  EXAMPLE: The pregnant woman is married on the 25th day of a 30-day month. Her husband has income of $1200 for the application month. $1200 divided by 30 days = $40/day x 6 days = $240 countable pro rata share of income for the month of the marriage.

- Compare the gross income to the specific percentage of the poverty level, depending on aid group composition and family size.

- If a family has both a pregnant woman/infant to age one and children of specified ages, a budget test for each group must be completed, using the appropriate income standards.

- The same family members may be used to determine family size for each budget. Work each budget as if the other budget does not exist.

  NOTE: No medical expenses may be deducted to reduce the income for comparison to the PLIS. Allowable income exclusions for coverage under this need standard are the same as for Families First cash assistance.

- If the BG is not eligible after completion of these steps, determine eligibility for other TennCare Medicaid categories as appropriate.

Budgeting Procedures for MA K : SSI Pass Along/Pickle categories & MA L , MA M: QMB, SLMB, OI, QDWI categories

- Determine the amount of the individual's monthly gross income. Exclude income as provided by law and detailed in the Income Chapter of this Manual.

- Apply the following disregards to the individual's countable income. Combine the eligible couple's countable income before applying disregards (if an eligible couple or if deeming is appropriate from an ineligible spouse to the eligible individual or eligible individual whose spouse has zero income).

    - Unearned Income

      Subtract up to $20.00 disregard that is not offset in full by unearned income. The result is the net earned income.

    - Earned Income

      Apply any of the $20.00 general disregard not offset by unearned income. Disregard $65.00 and then one-half of the remainder. The result is the net earned income. For blind recipients, apply the $20.00 disregard not offset by unearned income, disregard $85.00 and then ½ of the remainder, disregard $15.00 Blind Work Expense. The result is net earned income.

  NOTE: Deeming does not apply from parents of an institutionalized child.

Income Determination for SSI Pass Along/Pickle categories

- Combine the net earned and net unearned income and compare the total to the appropriate SSI-FBR. If there is a deficit of $1.00 or more, the individual is not eligible as a Pass Along or Pickle case. Refer the individual back to the SSA for a SSI application.

- Disregard all COLAs from Social Security benefits received by the individual (and ineligible spouse or parent(s), if applicable) at or since the termination of SSI. Compare the adjusted income to the current FBR for an individual. Approve for TennCare Medicaid if the income is equal to or less than the FBR for an individual. Deny or close if the income is more than the FBR.

Budgeting procedures for Combination Cases

Budgeting procedures for combination cases including an eligible institutionalized spouse, and cases where parental income is considered can be found in the SSI Pass Along/Pickle Chapter of this Manual.

Income Determination for QMB, SLMB, QI, QDWI categories

- Combine the net earned and net unearned income and compare the total to the appropriate PLIS for the category and BG size.

- If the income is equal to or less than the appropriate PLIS, the individual or couple is income eligible.

- If the income is greater that the appropriate PLIS, the individual or couple is NOT income eligible. More information is available in the appropriate Chapters of this Manual.

DEEMING INCOME FROM A FINANCIALLY RESPONSIBLE RELATIVE FOR CATEGORICALLY NEEDY GROUPS

Income considered available to any member of the Budget Group from a financially responsible relative (FRR) is deemed income. Do not deem income from a FRR who receives any type of Public Assistance, i.e. Families First or SSI.

Income from a FRR is deemed available to the individual while the individual and spouse share the same living arrangement. Income may be allocated from the HCBS spouse to the community spouse who applies for TennCare Medicaid when they reside together; however, no income is deemed from the community spouse to the HCBS spouse whose eligibility is determined as an institutionalized individual.

An institutionalized couple sharing the same room are treated as individuals rather than a couple.

A FRR's responsibility ends the month the individual and his/her TennCare Medicaid ineligible or TennCare Medicaid eligible FRR are separated for any reason such as admission to a medical institution for 30 consecutive days **or for individuals enrolled in HCBS, the individual is determined to need and to be likely to receive services for a continuous period of at least 30 days going forward**. If the individual or his/her spouse apply for TennCare Medicaid in the month of separation, his/her eligibility is determined as an individual only.

EXCEPTION: Under the Spousal Impoverishment provision, income of the institutionalized spouse may be allocated to the community spouse.

Spouse to Spouse Deeming and Dependent Allocation

This section describes how to determine the amount of income to deem from a FRR to a non-institutionalized adult, or an individual who does not meet the continuous confinement requirement and making an allocation of income to the spouse's dependents living in the home.

- Determine and verify the amount of the spouse's gross monthly income. Exclude the following from the gross income to determine the gross countable income:

    - Exclude any of the earned and unearned income which is detailed in those sections of the Income Chapter of this Manual.

    - The amount of child support payments, either court ordered or enforced under Title IV-D of the Social Security Act.

    - Title II, or other government, funds paid to the spouse to provide the individual chore/homemaker services.

    - The value of in-kind support and maintenance.

    - Work expense if the spouse is blind or is self-employed and disabled.

    - Any payment the spouse receives based on his needs and paid by a government entity, e.g., VA pension and any income used to determine the amount of the needs based payment.

    Dependent Allocation

    An allocation to each of the spouse's dependents living in the home is deducted from the gross countable income.

    A child's living allowance (LA) is allocated to each individual who meets ALL the following conditions:

    - Meets the definition of a child
    - Lives in the household
    - Is not a recipient of Public Assistance

    The maximum amount of a child's LA is equal to one-half the current SSI Federal Benefit Rate (FBR) for an individual in his own home. The amount of a LA is reduced by the amount of the child's own countable income. In addition to the standard income exclusions listed earlier, disregard up to $400.00 monthly gross earning of a student for allocation purposes only.

- Deduct a living arrangement (LA) from the gross countable income for each child living in the household.

- Deduct a living arrangement (LA) from unearned income.

- Deduct the remainder of the living arrangement (LA) from earnings if not totally offset by the unearned income.

- Compare the amount remaining after the dependent allocation(s) (post-allocation amount) to one-half the SSI-FBR for an individual.

- If the post-allocation amount is equal to or less than one-half of the SSI-FBR, there is sufficient income available to deem to the individual from the spouse. Count only the individual's own income to determine income eligibility.

- If the post-allocation amount is greater than one-half the SSI-FBR, deem the entire post-allocation amount as available to the individual from the spouse.

- If the ineligible spouse has zero income, include his/her needs and budget for a couple (i.e., eligible individual and ineligible spouse).

Calculating Income Eligibility

Follow these steps to determine income eligibility when part of the income is deemed available to the individual from the spouse.

- Add the spouse's earned income (post-allocation amount) to the individual's earnings. The result is the total gross earned income. Add the spouse's unearned income (post-allocation amount) to the individual's unearned income to determine the total gross unearned income.

- Apply the following disregards to the total gross income by type and in the order they appear here. The result is the net income.

    - Reduce the total unearned income, except for any needs based income, by $20.00. Carry any of the remaining $20 disregard not offset here to earned income. The result is the net unearned income.

    - Subtract any of the $20 general disregard not offset by unearned income. Subtract allowable work expenses from earned income: the first $65.00 and then one-half of the remainder. The result is the net earned income.

- Combine the unearned and earned income to determine net countable income. Compare the resultant net income to the Medically Needy Income Standard (MNIS) for two, if the adult is pregnant or under age 21.

BUDGETING FOR MEDICALLY NEEDY GROUPS

MA T Medically Needy Coverage for Children

The following is an overall outline of the budgeting procedure used to determine income eligibility for MN groups except for CSLA groups. Refer to individual Chapters in this Manual addressing each MN group for a discussion of specific budgeting methodologies.

- The BG is composed of the following individuals:

  - The child or children for whom assistance is requested.

  - The in-home siblings of the child(ren) for whom assistance is requested including an unborn child.

  - The in-home parent(s) of the above named child(ren) whose needs are not met by a FRR.

  - The alleged parent may be included in the BG only when deprivation exists for his/her child(ren). He/she may not be included until the child is born. When the alleged parent is included in the BG, all of his/her income is considered available. When he/she is not included, only his/her contributions are considered as income.

    NOTE: As of April 29, 2005, non-pregnant adults age 21 and older no longer qualify in the Medically Needy program

  - A caretaker relative/child(ren) whose needs are met by a spouse/(major) parent and who elects inclusion in the BG. NOTE: As of April 29, 2005, non-pregnant adults age 21 and older no longer qualify in the Medically Needy program.

  - A caretaker/relative other than a parent may be included with or without needs met by a FRR when inclusion is requested, and there is no parent is in the home, or the parent in the home is incapacitated, or the child in the BG is deprived of parental support. NOTE: As of April 29, 2005, non-pregnant adults age 21 and older no longer qualify in the Medically Needy program.

  NOTE: Do not include the needs or income of SSI, FF or other public assistance recipients, including individuals receiving VA Pension based on need.

- Countable income is budgeted as follows:

  - Apply the income exclusions described in the Income Chapter of this Manual.

- Exclude the Child(ren) with Income Sufficient to Meet His Needs. Exclude each child (except for the child(ren) for whom assistance is requested) with individually owned income sufficient to meet his needs unless the applicant/recipient wishes for them to remain in the BG.

- Apply to each individual's earnings, the earnings disregards in the following order:

    - $90 work expenses per month

    - Dependent care expenses up to $175 per month per dependent age 2 or older. Dependent care expenses up to $200 per month per dependent under age 2.

- Combine the individual net earnings and total gross unearned income of all BG members.

- Compare the net income to the MNIS appropriate to the size of the Budget Group.

    - If the **net income is equal to or less than the MNIS**, the group is "Exceptionally Eligible". Authorize benefits for the Aid Group members only. Exceptionally eligible individuals will receive continuous TennCare Medicaid coverage.

    - If the net income is **greater than the MNIS**, proceed to determine if the group is eligible under the Spend down provision. Individuals eligible under the Spend down provision must have medical expenses to qualify.

- Determine Eligibility Under the Spend Down Provision:

    - The Budget Group with income greater than the MNIS may reduce its countable net income sufficiently to result in the Aid Group's eligibility for benefits if the amount of its health insurance premium and incurred medical expenses offset the amount by which its income is in excess of the income standard for one month (Monthly Excess - ME).

        NOTE: Financial responsibility is limited to spouse for spouse and parent for child.

    - Apply the spend down provisions described later in this Chapter. If there are sufficient medical expenses to reduce the BG's ME to zero, benefits may be authorized.

SPEND DOWN PROVISIONS

LEGAL BASE: 42 CFR 435.831
STATE RULE: 1240-3-3-.06

Federal regulations provide that MN coverage groups with net income greater than the applicable income standard may achieve TennCare Medicaid eligibility if the family and/or children and their financially responsible relatives Spend Down the amount of their excess income on a monthly basis for medical expenses. Excess monthly income is the difference between net income and the appropriate Medically Needy Income Standard, based on Budget Group size. Apply the following policies to determine income eligibility under the Spend Down provision.

NOTE: The following spend down provisions apply to pregnant women and children applying for Medically Needy Medicaid as well as non-pregnant adults trying to gain coverage through the Standard Spend Down Program. Treatment of incurred expenses for those who have continuous eligibility and that process will be covered here and in Chapter 9.

Spend Down Period - The spend down period applies to pregnant women and children under 21 who are new applicants for Medically Needy Medicaid, pregnant women and children who are continuously eligible for Medically Needy Medicaid and Existing Medically Needy Adults who will be selected for SSD determination.

Establish the Spend down Period - Spend down coverage may begin:

- the date of application; OR
- the date spend down is met, whichever is later. The spend down date must be no later than the end date of the application month.

Incurred Medical Expenses

Continuous MN eligible individuals must have medical expenses incurred during the following periods to establish eligibility:

- Bills incurred during the month of application (whether paid or unpaid);
- Bills paid during the month of application (regardless of when the bill was incurred);
- Bills incurred during the three months prior to the month of application (whether paid or unpaid); and
- Unpaid medical bills incurred during the application month or three months prior to the application month during the continuous MN eligibility period may include expenses not paid by TennCare as covered expenses.

Examples of non-covered expenses are eyeglasses, hearing aids, walking devices for adults or costs in excess of TennCare coverage limits.

NOTE: Do not count bills paid during the three months prior to the application month unless the bills were also incurred during those same months. Do not count any bills incurred before the three calendar months prior to the month of application unless:

- Payment is made on those bills during the month of application and only the amount paid during the month of application is counted;

OR

- All of the following are met:
  - The bills were previously verified and documented as part of meeting spend down,
  - The individual has remained continuously eligible in a spend down category since that time,
  - The individual has met spend down each period in order to qualify, and
  - The bills remain unpaid and not written off by the provider.

In this case, the carryover that has not previously been used for the purpose of qualifying for spend down can be applied. (The carryover expense may be an unused portion of a bill or an entire bill.)

Medical bills of an individual not living in the home or not eligible for inclusion may also be counted if a budget group member or their FRR is legally obligated to pay them. This might include old bills of a child who is now over age 21 or bills a parent is obligated to pay due to a child support order when the child lives elsewhere, if the bill is incurred during the budget period as described above. This may also include medical bills of an individual who is now deceased.

If spend down is not met by the bills presented, add daily countable medicalexpenses incurred during the application month until spend down liability is reached. Use only the portion of the medical expense that is necessary to meet spend down. Document medical expense information clearly in the case record. Documentation should include:

- The name of the provider,
- The account number,
- The date of the service,
- The amount of the bill,
- How much was used,
- How much remains to be used for a future spend down period (carry-over)

Allowable Expenses Described

Allowable medical expenses include those expenses that are incurred within the application month or three calendar months prior to the application month whether paid or unpaid). Also, payments made on medical bills during the application month regardless of when the bill was

incurred are allowed. Allowable expenses are those for which the individual is still liable and that are:

- For medical or remedial care, including over the counter;
- verifiable and for which the individual provides substantiation,
- incurred by the eligible individual/couple and others as listed above and are the legal responsibility of the individual or his/her FRR and not subject to payment in full or in part by a third party.
- recognized under State Law – but not covered for the individual under the State's TennCare Medicaid plan or waiver;
- covered under TennCare Medicaid but incurred during the budget period (defined later).

NOTE: Do not include medical expenses that will be paid by TennCare Medicaid.

EXAMPLE: An AG member is hospitalized on September 10th and meets spend down of $800 on September 12th after incurring a total bill of $1600 as of that day. Because TennCare will be paying expenses incurred September 12th until September 30th, the excess over $800 cannot be used to meet spend down for a second SSD determination. The bill has to remain unpaid or not written off by the provider.

Medical expenses, including health insurance premiums and any unpaid costs incurred within the budget period (application month or three prior months) for new applicants including pregnant women and children under age 21, and recipients including pregnant women and children, and existing Medically Needy adults are used to spend down the excess income.

If a medical expense is subject to partial payment by a third party, include only the portion for which the individual is liable in the determination of total incurred medical expenses. NOTE: When an individual is receiving Medicare and QMB, the state pays the Medicare deductible (not the MCO). If an individual has received a bill for the deductible amount, this bill will be paid by the State; therefore, it is not an allowable medical expense.

Bills incurred during TennCare eligibility which are subject to TennCare reimbursement are not considered outstanding for subsequent spend down periods even if not paid by TennCare

New bills, if incurred within the budget period, are deductible for the period in which they are incurred whether or not they have been paid with loan proceeds or with a credit card. No carryover expense will be allowed at the next spend down review because the bill has been paid in full. Do not allow the loan or credit card payment as a medical expense at the next review.

Expense(s) may be allowed if payment is made by a public program of a state or political subdivision that is other than a TennCare Medicaid program and there is a cost for the service (free service to the public cannot be deducted).

EXAMPLE: Ms. Jones filled a prescription through a county hospital drug program where an expense would normally be incurred. The cost of the prescription may be used as a spend down expense. However, if Ms. Jones took her 2-year old to the Health Clinic for his immunizations and this service is provided free, no expense is incurred. This may not be use as a spend down expense.

Over the counter (non-prescription) medicine such as cold remedies, vitamins, etc. is an allowable medical deduction. Deduct up to $10.00 a month for these expenses without verification using only the client's statement.

Medical expenses related to maternity care (global fee) are considered incurred the month the physician presents a bill once services have begun (i.e., initial examination by the physician at a minimum). All other medical expenses are considered incurred the date the service is provided.

EXAMPLE: Ms. Smith had an initial pregnancy examination in January. She received a bill in February from her physician in the amount of $1500 which included all charges for her prenatal care and delivery. She applied for Medicaid in February and has to meet spend down of $800. Since her physician has billed her, expects payment and the service was incurred within the three months prior to her application date, she may use this bill to meet spend down.

EXAMPLE: Ms. Jones had an initial pregnancy examination in January. Her physician will charge her $1500 for prenatal care and delivery for her baby that is due in July. She was billed $200 in February and must pay $200 per month until the fee is paid. She applied for Medicaid in February and must meet spend down of $700. The only fee that she may use to meet spend down is the $200 for which she was billed and must pay in February.

EXAMPLE: Ms. Potter is pregnant and had an initial examination in January. Her physician charges $45 per appointment plus lab expenses and a delivery fee of $800. The delivery fee is not due until the baby is born. She paid the $45 appointment fee in January and has a receipt. She received a bill for $65 for January's lab work. Ms. Potter applied for Medicaid in February. She must meet spend down of $600. She can use the $45 fee that was incurred and paid in January and the bill for $65 that was incurred at the same time but remains unpaid toward spend down. She has not been billed for the delivery fee. She, of course, must have additional qualifying bills to become eligible.

Always verify, if possible, the reimbursement or payment of medical expenses by third parties (i.e., insurance, medical support, etc.) before allowing a deduction. If verification of the reimbursement cannot be obtained within time constraints (application or change report processing period), determine from the third party:

- type of expense it will cover
- rate or percentage or anticipated amount of reimbursement
- anticipated date of reimbursement

If all possible efforts have been made and verification cannot be obtained about third party payment, allow the portion of the expense the individual states he is responsible for.

Budgeting Medical Expenses

Regular recurring medical expenses (e.g., insurance premiums in the month due, installment payments for medical bills incurred during TennCare Medicaid ineligibility or TennCare Medicaid non-covered medical/remedial services) are counted as incurred the date of application.

Use only the portion of the medical expense that is necessary to meet Spend Down.

Use any remaining medical expenses to carryover for the next Spend Down period, if still owed or paid during the Spend Down reapplication month in question.

When carrying unused medical expenses forward for use in another Spend Down period, do not allow any amount that TennCare Medicaid or a third party will pay (i.e., covered medical bills incurred on day Spend Down met through the end of the TennCare coverage period).

Qualifying Expenses

The following is an overview of the type of medical expenses considered "Allowable Medical Expenses" and for which a deduction for payment is allowed in spending down excess income in Medically Needy cases:

- Acupuncture Services
- Bed hold at LTCF Medicaid rate
- Dental expenses
- Doctor's fees
- Drugs prescribed by a physician prior to TennCare Medicaid eligibility
- Guide dogs
- Hospital charges
- Kidney transplant expenses
- Medical charges in tuition fees
- Nursing home costs
- Nursing services
- Prosthetic devices
- Psychiatric care
- Special education
- Substance abuse treatment
- Transportation for medical/remedial purposes

NOTE: Under TennCare coverage, all medically necessary medical services are provided. Any costs incurred for medical services during TennCare Medicaid eligibility are not allowable Spend Down expenses unless the cost is due to premiums, co-pay and deductibles as TennCare enrollees, or services not covered such as dental, hearing, and eye care for adults.

Allowable Medical Expenses

The following is a specific description of the types of medical expenses considered "allowable Medical Expenses " and for which a deduction for payment is allowed in spending down excess income in MN cases:

- **Doctor's fee**s - Practitioners and others providing medical services, physicians, surgeons, dentists, optometrists, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, Christian Science.

- **Drugs Prescribed by a Physician** - Medicines and drugs prescribed by a doctor incurred prior to establishing TennCare Medicaid eligibility and which remained unpaid or paid in the month under consideration (i.e., Spend Down month).

- **Guide dogs** - Guide dogs for the blind or deaf and the costs of their maintenance are allowable medical expenses.

- **Medical care charges in tuition** - Charges for medical care included in the tuition fee of a college or private school which is paid on a monthly basis, provided that a breakdown of the charges is included in the bill or is furnished separately by the institution.

- **Nursing Services** - Nursing services include nursing care in a client's home, if for the purpose of treatment or alleviation of a physical, mental, or emotional disorder and ordered by a physician. The care needed must be medical, e.g., administering medication or therapy. Cost of services solely domestic in nature, such as, the preparation of meals and the performance of housework is not deductible.

- **Organ transplant expenses** - Expenses for donor or prospective donor for an organ transplant including surgical, hospital, laboratory charges and transportation expenses.

- **Prosthetic devices** - Artificial teeth, limbs, eyeglasses, hearing aids, and component parts, and crutches.

- **Psychiatric care** - Psychiatric care primarily for alleviating a mental illness or defect; the cost of maintaining a mentally ill individual at a specially equipped medical center where the individual receives continual medical care.

- **Special education for handicapped** - Special school for mentally or physically handicapped individuals if for the alleviation of handicap. Example: The costs of sending a blind child to school to learn Braille, or a deaf child to lip-reading classes, are medical expenses. The costs of meals and lodging, if supplied by the institution, and/or ordinary education furnished incidental to the special services are medical expenses.

- **Substance abuse treatment -** Treatment at a therapeutic center for drug addicts or alcoholics, including meals and lodging furnished as a necessary incident to the treatment.

- **Transportation -** Transportation essential to medical care, e.g., bus, taxi, train, or plan fares, and 42 cents for each mile that the client's car is used for medical purposes, in addition to parking fees and tolls.

- **Over-the-counter (non-prescription) medicine -** Over-the-counter (non-prescription) medicine is an allowable medical expenses. Deduct up to $10 a month for these expenses without verification, using only the client's statement. All of these expenses must be verified if the amount is more than $10 per month.

Non-Qualifying Expenses

The following incurred expenses are non-qualifying and cannot be deducted when determining Spend Down eligibility:

- Expenses that are covered by the State's TennCare Medicaid plan and were incurred during a period of eligibility. For example, a prescription drug that is not deemed medically necessary.

- Expenses incurred prior to the individual becoming eligible for TennCare Medicaid or in a prior period for charges that have been written off as uncollectible or have been forgiven by the provider.

- Expenses that are not "medical" for purposes of this section.

Medical/Health Insurance Premiums

Health insurance premiums may be deducted as a Spend Down expense only when payment is due, even if paid in another month including the Spend Down under consideration.

Premiums are deducted for health insurance that shares these characteristics:

- It is reported to the TennCare Medicaid Bureau as a third party medical resource (TPR), AND

- It's benefits are assignable and the eligible individual has agreed to assign them to the State., AND

- The premiums are paid by the eligible individual, not by a third party.

NOTE: The State pays the Medicare premiums for all SSI eligibles and SSI Pass Along/Pickles. Do not deduct Medicare premiums for these groups of individuals or individuals approved as a Qualified Medicare Beneficiary

(OMB) or Special Low Income Beneficiary (SLMB) or Qualifying Individuals (QI).

Verification of Third Party Payments

Always verify, if possible, the reimbursement or payment of medical expenses by third parties (i.e., insurance, medical support, etc.) before allowing a deduction. If verification of the reimbursement cannot be obtained within time limit constraints (application or change report processing period), determine from the third party the:

- type of expense it will cover
- rate or percentage or anticipated amount of reimbursement.
- anticipated date of reimbursement.

If all possible efforts have been made and verification cannot be obtained about third party payment, allow the portion of the expense the individual/BG states |(s)he/they is/are responsible for.

Compare Total Incurred Expense to ME

- Compare the amount of expenses incurred by the group to the monthly excess (ME).
- If the total expenses exceed the ME, proceed to determine the date the Spend Down requirement is satisfied and eligibility begins during the application month.
- Use only the amount of an individual's or AG's medical expenses as necessary to meet the Spend Down liability.
- Any excess unpaid medical expenses may carryover to be used for later periods of eligibility if still owed and considered collectible at that time. (See Example above).

NOTE: Bills which are subject to reimbursement by TennCare Medicaid are not considered outstanding for subsequent Spend Down periods.

Determine the Date Medical Expenses Equal ME

The BG satisfies the Spend Down requirement resulting in eligibility for the Aid Group effective the day the total medical expenses at least equal the monthly excess on the application date or no later than the last day of the application month.

Authorize TennCare Medicaid benefits for the Aid Group beginning the day the Spend Down requirement is satisfied and ending the last day of the month. Eligibility cannot begin prior to the application date. There are no retro provisions.

Changes During Spend Down Coverage

Changes in income and resources must be taken into consideration on a Spend Down case as on any other Medicaid case. However, under the TennCare waiver, an individual eligible for one month of coverage is extended 12 months from the initial day of eligibility and the reported change in income or resources will affect the current SSD eligibility.

When Spend Down is met, authorize the approval with a one-month spend down period only. Once eligibility appears on TennCare interchange, close the spend down on ACCENT with the appropriate code. At the end of the 12-month extension, the Bureau of TennCare will send a 30-day advance notice to the AG to reapply.

Medical expenses incurred for TennCare covered services during a TennCare eligibility period cannot be used to Spend Down income for any Medically Needy categories. Non-covered services continue to be an allowable deduction. They include but are not limited to:

- Dentures
- Eyeglasses
- hearing aids
- walking aids

Any case open on ACCENT that has not met Spend Down will continue to report any changes in income and resources.

DEEMING INCOME FROM A STEP-PARENT OR MAJOR PARENT IN MEDICALLY NEEDY BUDGETING

A caretaker relative/individual(s) (i.e., parent, child, minor mother, grantee relative other than parent, married minor) whose needs are met by a spouse or (major) parent may elect inclusion in the BG; however, as of April 29, 2005, non-pregnant adults age 21 and older no longer qualify in the Medically Needy program.

Determining Eligibility of the Caretaker Relative/Individual(s)

To determine eligibility of the caretaker relative/individual(s), apply the following:

- The excluded income provisions described in the Income Chapter are applicable to stepparent/(major) parent/spouse income.

- The countable income provisions described earlier in this chapter are applicable to stepparent/(major) parent/spouse income.

- Determine gross earnings of the stepparent/(major) parent/spouse.

    - Apply the $90.00 work expense to determine net countable earnings

    - Add unearned income to the net earnings to determine total net income.

    - Apply the following deductions to the Net Income:

        - MNIS per number of in-home dependents including the step (major) parent/spouse (do not include parent of child(ren) or any potential BG members);

        - Contributions to out-of-home dependents paid by the stepparent/major parent/spouse; and

        - Child support/alimony to out-of-home dependents paid by the stepparent/major parent/spouse who requests inclusion in the BG.

NOTE: As of April 29, 2005, non-pregnant adults age 21 and older no longer qualify in the Medically Needy program

Deprived Child(ren) (and/or Individuals with no Countable Deemed Income) Budget.

- If deemed income is equal to or less than the appropriate MNIS for the individuals with the FRR, include the caretaker (CR) and/or intact or deprived child(ren) in one budget group (BG). Do not include deemed income from the stepparent/major parent.

- Use the MNIS for all members of the AG requesting coverage throughout all budget steps.

- Add the income of all AG members and apply disregards as appropriate.

- If the total net income is equal to or less than the MNIS, the child(ren) and/or individual is exceptionally eligible.

If the total net income is greater than the MNIS, subtract the MNIS from the net income. The result is the monthly Spend down amount.

Budget Steps for Individuals in BG with Needs Met by an FRR but Who Requests Inclusion:

- If deemed income is more than the appropriate MNIS for the individual for whom the FRR is responsible, consider the total deemed income amount in the budget of individuals whose needs are met by the stepparent/(major) parent.

- It is necessary to work 2 separate budgets with each budget containing all BG members and their incomes.

- In the budget for BG members with needs met, include the deemed income also and follow usual procedures for determining Medically Needy eligibility.

- It is possible for a BG to have some individuals who are exceptionally needy and others who are spend down eligible, or both are spend down, or not eligible at all.

EXAMPLE: Mrs. Telon applies for Medicaid. She has two children by previous marriage who receives $150 per month child support and one child by Mr. Telon, her current husband who is in the home. The only other income is Mr. Telon's earnings of $800 a month.

Deeming Budget from Mr. Telon to Mrs. Telon and their child:

800	Gross Earnings
- 90	Flat Work Expense
710	Net Earnings
- 175	Dependent Deductions (MNIS for Mr. Telon)
535	Deemed Income is greater than MNIS of $192 for Ms. Telon and "their" child

Budget #1 for "Her" Two (2) Children

100	Net Income (150 Child Support – 50 bonus)
- 325	MNIS for 4 persons (Mrs. Telon, "her" 2, "their" 1)
0	Exceptional Eligibility for "Her" 2 children

Budget #2 for Ms. Telon and their 1 Child

100	Child Support (150-50 bonus)
+ 550	Deemed Income (for Mrs. Telon and "their" child)
650	Net Income
- 325	MNIS for 4 persons (Mrs. Telon, "her" 2, "their" 1)
325	Monthly Spend down Amount for Mrs. Telon and "their" child

Budget Steps for Caretaker of PLIS/MA J child(ren):

The caretaker of a deprived child may be eligible when the child is eligible in another BG such as SSI or the PLIS/MA J category; if Medicaid has been requested and there is a medical need. Her eligibility is determined under the Medically Needy (MA T) guidelines if not FF eligible. The caretaker may be "Exceptionally Eligible" or "Spend down Eligible" dependent upon income and resources.

EXAMPLE: Mrs. Telon applies for Medicaid. She has a three-year-old receiving MA J and a 14-year-old receiving SSI check of $446 per month. Mrs. Telon has no resources and is pregnant. Because Mrs. Telon is financially and technically eligible, benefits can be authorized from date of application.

0	
- 175	MNIS for Mrs. Telon only
0	Excess – Exceptionally Eligible

NOTE: MA J children may also be included in MNIS.

INSTITUTIONALIZED INDIVIDUALS BUDGETING

(HCFA Transmittal MCD-984(2000)
(42 CFR 435.722 (c)

Policy Statement

Institutionalized cases include those individuals confined to a medical institution (including services in a hospital, nursing facility, intermediate care facility, or intermediate care facility for persons with mental retardation) and/or enrolled in a HCBS program or any combination thereof that has been continuously received for at least 30 consecutive days if he is not an inmate or in a mental institution; or for individuals applying to enroll in a Home and Community Based Services (HCBS) waiver program, the individual has been determined to need and to be likely to receive services for a continuous period of at least 30 days going forward; and any individual who dies while in a long-term nursing care prior to 30 days continuous confinement.

For institutionalized individuals whose income is under the Medicaid Income Cap (MIC), the applicable disregards from gross income include:

- A Personal Needs Allowance (PNA) of $40.00 or 200% of the SSI-FBR for the individuals in HCBS.

- A spousal and/or dependent allocation if applicable, AND

- Health insurance premiums.

Spend down eligibility is not available for nursing home patients. However individuals whose income is over the MIC may qualify by establishing a Qualified Income Trust.

Spousal Income Allocation in Institutional Cases

The Medicare Catastrophic Coverage Act (MCCA) of 1988 provides a more liberal treatment of the income of the institutionalized individual who has a legal spouse living at home (i.e., a community spouse).

If the community spouse (CS) applies for Medicaid/TennCare, the contribution from the institutionalized spouse's income will be applied as unearned income. NOTE: As of April 29, 2005, non-pregnant adults age 21 and older no longer qualify in the Medically Needy program.

A CS receiving SSI, FF, VA Pension, or Medicaid/TennCare, or other benefits does not have to accept the total or any of the income allocation if it will result in termination of or decrease in those benefits. Be sure the SSI-CS understands to report any allocation received to the Social Security Office. The DHS caseworker handling the nursing home case is required to notify other DHS caseworkers of any associated case (FS, FF, Medicaid/TennCare) of the CS's allocation amount.

If a couple is married but living separately and considering themselves to be separated, the spousal income allocation may be allowed if both members of the couple agree to the allocation, and the CS is not institutionalized also. If the CS lives out of state, an income allocation may be made if the CS can be located and they are still married.

Determining Patient Liability for the Institutionalized Individual

Once the institutionalized individual has been determined technically, resource and income eligible using the Medicaid Income Cap (MIC), his/her patient liability is determined by allowing the following deductions:

- Personal Needs Allowance (PNA) of $40 for LTCF or the SSI Federal Benefit Rate (FBR) for HCBS cases or the amount of VA A&A payment (which is currently $90).
- Spousal/Dependent Allowance not to exceed the maximum of $2610.00 effective January 1, 2008 per family.
- Health insurance premiums, coinsurance and deductibles
- Non-covered medical expenses for medical and remedial care not subject to third party payments (Item D).
- Adjustments due to errors or omissions in a previous computation (Patient Liability Overcharges).

The spousal income allocation will not affect the Qualified Medicare Beneficiary (QMB) eligibility of the nursing care spouse, as its income test is applied against gross income before any deductions apply for the patient liability deduction.

Determination of Spousal/Dependent Income Allocation

Apply the procedures outlined in this section to determine the amount of the spousal/dependent allocation.

Standard Maintenance Amount (SMA)

The spousal allocation includes a Standard Maintenance Amount (SMA) based on 150% of the Federal Poverty Level (PLIS) for 2 persons divided by 12 months (rounded up to the nearest whole dollar). The amount changes effective July 1 of each year. The current SMA is $1,750 effective July 1, 2008.

Excess Shelter Allowance (ESA)

An Excess Shelter Allowance (ESA) is allowed when the total shelter costs for rent, mortgage, taxes and insurance, any maintenance charges for a condominium or cooperative, and utility costs (based on the Food Stamp Standard Utility Standard) exceeds 30% of the SMA rounded upward to the nearest dollar. (The ESA = total shelter costs – 30% of the SMA). The current value of 30% of the SMA is $525 effective July 1, 2008.

Use the utility allowance when any utility is paid (as used in the Food Stamp program). When there is no or reduced cost to the Community Spouse (CS) because the cost of a particular item is paid directly by a third party in cash or in kind, reduce the amount of the Food Stamp utility allowance (SUA) by the amount of the third party payment.

Add together rent, mortgage, taxes, insurance and utility allowance. Subtract from this total, 30% of the SMA, to determine the ESA. Add together the ESA and the SMA minus the CS income to determine the CS allocation. (ESA + SMA = total needs – CS income = CS allocation).

Community Spouse Countable Income

To determine the CS's otherwise available income, "otherwise available countable income" is defined as income over which the CS has control and which is actually available to the CS.

EXAMPLE: The CS is employed and income tax, Social Security and health insurance premiums are deducted from the paycheck. Count the income tax and Social Security deductions as money unavailable to the CS because the CS does not have a choice about (control over) these deductions. Count the

health insurance premiums as money available to the CS because the CS does have a choice (control over) that deduction.

Types of income which are not considered available to the CS are child support payments and other types of court-ordered payments, etc., made by the CS.

Countable income includes SSI and/or Families First benefits for purposes of determining the spousal/dependent allocation. Compute budgets with and without the SSI/FF income to allow the CS a choice of whether to accept some, all or none of the allocation.

If the CS has fluctuating earnings, average and convert the CS's countable income which reflects anticipated earnings for the prospective period (i.e., the next 3 months). The CS must verify his/her income every 3 months and the allocation budget must be recalculated accordingly.

Dependent Allocation

Dependent relatives for purposes of this policy include all persons who can be or are being claimed as tax dependents and includes adult dependent children, parents and/or siblings as well as minor children.

A dependent does not have the option of declining all or a portion of the income allocation for any reason according to the Health Care Financing Administration's (HCFA) interpretation of the MCCA, even if needs-based benefits may be decreased or lost because of the allocation.

The dependent allocation(s) equals the SMA for the CS minus the dependent's own gross countable income divided by 3 (SMA-gross countable income = deficit + 3 = dependent allocation).

The dependent allocation is figured separately from the CS allocation. When the CS has more than enough income to meet the SMA and ESA, a zero allocation is used for the CS when adding it to the dependent allocation to get the total spousal/dependent allocation.

Calculation of Spousal/Dependent Allocation

Dependent (Community Spouse in home)

Although the calculation of the allocation for spouse and dependent are done separately, the total of both allocations cannot exceed the maximum income allocation amount.

EXAMPLE: Mr. Dean has a spouse and two dependents living at home. Mrs. Dean receives $600 Social Security for herself and the two dependents ($200 each). She pays the mortgage of $300 a month which includes taxes and insurance. She also pays a monthly light and water bill.

Formula used in determining Spousal/Dependent Allocation

- Shelter Cost

400.00	Mortgage taxes, insurance
+ 293.00	Standard Utility Allowance (SUA)
693.00	Total Shelter Cost
- 525.00	(30% of SMA)
168.00	Excess Shelter Amount (ESA)

- Spousal Allocation

1750.00	SMA (at that time)
+ 525.00	SA
2275.00	Total Needs
- 600.00	CS income
1675.00	Deficit – Spousal Allocation Amount

- Dependent Allocation

1750.00	
- 200.00	
1550 / 3	= $516.66 each dependent x 2 = 1033.32

- Spousal Allocation

1675.00	Spousal Allocation
+ 1033.32	Dependent Allocation
2708.32	Total Spousal/Dependent Allocation

- The CS/Dependent allocation may not exceed the maximum as detailed in the Institutionalized Individuals Eligibility Chapter of this Manual.

- Dependent (No Community Spouse in the home)

- Determine the dependent allocation by deducting the dependent's net countable income from the appropriate MNIS when there is no community spouse in the home. The net countable income is determined by subtracting $65, then ½ of the remainder from earned income.

ITEM D DEDUCTIONS FOR INSTITUTIONALIZED INDIVIDUALS

The law allows the deduction for expenses incurred by the eligible individual for medical or remedial care that are recognized by state law as medical and/or remedial care items but are not included in the State's Medicaid/TennCare plan. Tennessee calls these non-covered expenses Item D.

Cost items are those medical/remedial services and/or goods that must be provided by the nursing care providers. Cost items cannot be charged to patient or allowed as an Item D deduction.

Allowable Item D Expenses

The deduction of these expenses is subject to the following limitations:

- The expenses(s) must not be subject to payment by a third party which does not expect reimbursement, e.g., medical/health insurance, the individual's spouse or family or medical trust fund, Medicare, etc.
- The expense may be unpaid OR paid by the client during the month(s) of eligibility determination OR paid by a member of the client's family and reimbursement is expected by the family member.
- The expense must not have been allowed previously as a necessary item.
- The expense must be outstanding and considered collectible by the party who provided the medical service and one for which the client is legally liable.
- Medical expenses incurred during Medicaid/TennCare ineligibility do not impact on whether the bill is an allowable medical expense. EXAMPLE: Mrs. Carter applied for Medicaid/TennCare for the month of January. She did not meet Medicaid/TennCare eligibility for that month. She reapplied for March. The expense applied in the previous month, but which did not result in eligibility, may be used as an Item D in a later month if still owed and there are plans to pay the expense.

NOTE: Non-covered prescriptions in a nursing home or HCBS cannot be used as an Item D expense for those with Medicare Part D.

Prescriptions that are not covered by Medicare Part D are not allowed as an item D deduction. TennCare no longer offers prescription coverage to individuals who are dually eligible for both Medicare and Medicaid; this includes individuals who are dually eligible in a long-term-care or HCBS setting. The nursing home industry throughout Tennessee has been notified of this policy by the TennCare Bureau.

NOTE: Non-covered prescriptions in a nursing home or HCBS cannot be used as an Item D expense for those with Medicare Part D.

Setting up a Deduction Schedule

A deduction schedule may be used to allow for a medical expense in determining eligibility and for Item D deductions of institutionalized individuals.

Item D deductions are made by using expenses from a previous quarter to project Item D expenses for a subsequent quarter. "Quarter" for the purposes of this section need not be calendar quarters but may be any 3 consecutive months. Expenses for the three months prior to the processing month plus any unused expenses for any prior month(s) are computed and projected effective the month after the processing month for a three month period.

Example: expenses incurred in May, June and July are processed in August and made effective for September, October, and November.

Once an Item D projection has been made, the next redetermination is due the third month of the projected quarter. For example, using the above projected quarter of September, October, and November, the next redetermination is due in November (processing month) using expenses for August, September and October to project for December, January and February.

An "adjustment to actual" will be made for each quarter's Item D's after the initial Item D determination.

Expenses incurred at any time are allowable as Item D's when there is a repayment plan, or the client expresses an intent of paying on the expense during the quarter under consideration. To allow deduction of these expenses the caseworker must determine:

- The total amount the client owes the provider and the outstanding balance.
- The date(s) the service(s) was provided.
- The amount of each monthly payment.
- The dates the first and last payments are due.

Allow deductions as payments are made during the months which are budgeted during the processing month. Do not continue to allow deductions for payment of expenses if it is discovered that payment is not being made, regardless of the type of payment or the existence of a repayment plan. Installment payments will be subject to the "adjustment to actual" process; however, one-time payments are not, as indicated below.

NOTE: Payment can only be made from the patient liability amount, not from the person's trust account or personal needs allowance. If the patient liability is already zero, no Item D can be allowed.

One-time Payments

One-time payments are those payments for medical/remedial expenses of $100 or more that are incurred only once and which are not paid in installment payments. One-time payments are not subject to the adjustment to actual process. They include expenses such as, eyeglasses, hearing aids, or dentures. One-time expenses may be deducted all in one month and removed effective the following month or prorated over 3 months.

On the data base, these expenses are encoded medical expenses rather than the Item D screen, AEFMD. The caseworker must set an Expected Change to remove the deduction of a one–time expense on a timely basis.

Qualifying Expenses

Allow deductions for payment of the following types of medical expenses as Item D's:

- **Acupuncture Services**

- Doctors' Fees - Fees for physicians, surgeons, dentists, optometrists, chiropractors, osteopaths, chiropodists, podiatrists, psychiatrists, psychologists, Christian Science practitioners and others for medical services are allowable deductions if incurred during periods of Medicaid/TennCare ineligibility.

- **Guide Dogs**- Guide dogs for the blind or deaf and the costs of their maintenance are allowable medical expenses.

- **Organ Transplant Expenses** - Expenses for donor or prospective donor for an organ transplant including surgical, hospital, laboratory charges and transportation expenses are deductible unless covered by Medicaid/TennCare during an eligible period.

- **Medical Care Charges in Tuition Fees** - Charges for medical care included in the tuition fee of a college or private school, or in the "file care" fee of a retirement home which is paid on a monthly basis, are allowable expenses provided that a breakdown of the charges is included in the bill or is furnished separately by the institution.

- **Prosthetic Devices** - Artificial teeth, limbs, eyeglasses, hearing aids, and component parts, and crutches are qualifying expenses if not provided by the MCO during a period of eligibility. Costs of examinations and upkeep of devices are also allowable deductions subject to limitations established by the TennCare Bureau.

- **Special Education for the Handicapped** - Special school for mentally or physically handicapped individuals if for alleviation of handicap. Example: The costs of sending a blind child to school to learn Braille, or a deaf child to lip

reading classes, are medical expenses. The costs of meals and lodging, if supplied by the institution, and of ordinary education furnished incidental to the special services are also medical expenses if these expenses are not provided through the MCO. MCO's on a case by case basis may provide tuition at a private school, if it can be determined that this service is preventive in nature.

- **Special Equipment** - Special equipment, such as, a motorized wheelchair, one wheelchair ramp for the individual's place of residence, or an automobile especially equipped for use by a handicapped person are qualifying expenses.

- **Transportation** - Transportation essential to medical care, e.g., bus, taxi, train, or plane fare, and 42 cents for each mile that client's car is used for medical purposes, in addition to parking fees and tolls is an allowable medical expense.

- **Nursing Services** - Nursing services include nursing care in client's home if for the purpose of treatment or alleviation of a physical, mental, or emotional disorder as prescribed by a physician. The care needed must be medical, e.g., administering medication or therapy. Cost of services solely domestic in nature, such as, the preparation of meals and the performance of housework is not deductible.

- **Psychiatric Care** - Psychiatric care primarily for alleviating a mental illness or defect and the costs of maintaining a mentally ill individual at a specially equipped medical center where the individual receives continual medical care are allowable expenses if not incurred during Medicaid/TennCare ineligibility.

- **Hospital Charges (in Tennessee or another state)** - Qualifying expenses are hospital services, therapy and similar services, nursing services, (including nurses' board), laboratory, surgical, obstetrical, diagnostic services and x-ray fees not incurred during Medicaid/TennCare eligibility. Payment for sitters is not allowable, either in the hospital or the home.

- **Substance Abuse Treatment** - Treatment at a therapeutic center for drug addicts or alcoholics, including meals and lodging furnished as a necessary incident to the treatment is a qualifying expense if not incurred during Medicaid/TennCare eligibility.

- **Legend Drugs** - Allow the amounts charged by the provider if not incurred during a period of Medicaid/TennCare eligibility if the individual does not have Medicare Part D. TennCare covers all "medically necessary" prescriptions; therefore, no deductions can be made for prescriptions not paid by TennCare during a period of TennCare coverage.

- **Dental Services Provided in a LTCF** - There are certain requirements that must be met by the mobile dental service providers in order to have their services

- These are the requirements of the mobile dental service:

    - To obtain a signed consent form from the responsible party prior to performing any dental services. If the responsible party fails or refuses to sign the consent form and has not made any arrangements for alternative dental care, the long-term care facility is authorized to sign the form on behalf of the resident. The consent will remain valid for the length of the resident's stay (only one form per patient, not one per procedure), unless otherwise revoked by the responsible party.

    - To deliver the consent form, along with the verification of services form, via hand delivery, mail or facsimile to the respective DHS office.

    - To contract with a dentist licensed in the State of Tennessee who is a Medicare/Medicaid provider. A licensed dentist must perform all services. The dentist's name and provider number must be entered on the Item D request form prior to submitting the bill to DHS.

    - To create and supply all new forms that are submitted from the mobile dental service provider and the long term care facility. The facility should ensure that a copy of these forms is kept on file in the patient records at the facility, along with proof that the services were provided by a licensed dentist.

- These are the requirements for DHS:

    - Prior to authorizing any Item D expense received from Magnolia Mobile Dental Service, Inc., the caseworker must view and document in the data base that the consent form, the Item D request form, and the verifications of service form have been provided.

    - Any services related to the provision of dentures deemed medically necessary must be thoroughly documented in the electronic case record. Process the Item D request within thirty (30) days after receipt in the county office.

    - Once the bills have been processed, the EC must notify the responsible party and the long term care facility of any action taken to approve (via data base notice and the appropriate data

base screen) or deny (via the data base free form) the expenses as an Item D deduction. These expenses will be deducted from the patient's countable income. This will reduce the patient liability.

NOTE: Payment can only be made from the patient liability amount, not from the patient's trust account or the personal needs allowance. If the patient liability is already zero, then payment cannot be allowed.

Along with the changes in polices and procedures, new forms were created to aid in the processing of dental expenses once they have been submitted to DHS. The forms and their use are as follows:

- Consent for Dental Treatment - A copy of this form should be submitted to DHS via hand delivery, mail or facsimile to verify that the responsible party or the long-tern care facility has given consent for a patient to have dental treatment. The original should be kept on file at the long-term care facility. The consent form will remain valid as long as the patient resides at the long-term care facility.

- Item D Request – This form should be submitted to DHS via hand delivery, mail or facsimile, reporting that a particular service has been provided and the cost of those services. This form should be completed with the name of the dentist and his/her licensing number.

- Verification of Services – This form should be completed and signed by a long-term care facility representative verifying that the service identified on the Item D request has been completed. This form should be submitted simultaneously with the Item D request form.

- Denture Medical Necessity Form – This form should be completed and signed by the Attending Physician or the Medical Director of the facility to proceed with providing dentures.

NOTE: The above forms will be created and supplied to the long term care facility nursing home by Magnolia Mobile Dental Services Inc. However, DHS will maintain a copy of the Verification of Services Form in our GroupWise Default Library to provide to the long-term care facility upon request.

Non-Qualifying Expenses

The following incurred expenses are non-qualifying and cannot be deducted when determining patient liability.

- Expenses for LTC residents for items identified as SNF/IDV cost items in the State's Medicaid plan. At least 1 medication in each of 5 Non-Legend Therapeutic categories must be supplied by the LTCF: Analgesics, Antacids, Cough and Cold Remedies, Laxatives, and Miscellaneous.

- Expenses incurred prior to the individual becoming eligible for Medicaid/TennCare or in a prior period that meet any of the following conditions:

    - Charges that have been written off as uncollectible or have been forgiven by the provider.
    - Expenses subject to payment (in full or in part) by third party resources (e.g. insurance, court-ordered medical support, etc.).

- Expenses that are not "medical" for purposes of this section.

Item D Adjustment to Actual

An adjustment to actual is the process of reconciling projected Item D's with Item D's actually incurred during the same months. The difference between the actual and projected expenses is then added to or subtracted from the actual and projected expenses over the next quarter. The adjustment to actual is never made if the individual is claiming an Item D deduction for the first time, or it has been more than a quarter since the last Item D was incurred.

An adjustment to actual is made only if there were projected Item Ds (not including one-time expenses) for any months of the previous quarter. NOTE: A projection of zero ($0) due to the adjustment to actual process in any month in the previous quarter is subject to an adjustment to actual if Item Ds were actually incurred.

Item D expenses used in the processing month to project expenses for a subsequent quarter will include:

- Expenses for the 3 months prior to the processing month, PLUS

- Any unused expenses from any past period which remain due, have not been previously used as expenses, and which will be paid on during the projected quarter.

Item D expenses do not include any one-time expenses of $100 or more for one–time purchase of glasses, hearing aids, dentures, etc., as these expenses will cause radical fluctuations in the adjustment to actual process.

During an initial Item D determination:

- Add countable expenses for the previous three months prior to the processing month;

- Divide by three and project the average monthly amount effective the month following the processing month;

- Schedule the next redetermination for the third month of the projected quarter.

EXAMPLE: Months 1, 2, 3 4 5, 6, 7

Expenses Incurred----------Processing Month----------Projected Months

Item D redeterminations for cases in which there was a projected expense for any month of the prior quarter must be adjusted to actual. To adjust to actual:

- Determine the actual expenses for the three months prior to the processing month

- Subtract the total projected expenses for the three months prior to the processing month from the total actual expense determined for those same months

- The + or – difference determined above is either added to or subtracted from the actual to determine the amount to be projected for a subsequent quarter.

EXAMPLE #1: Item D (Re)determinations:

Mr. A reports his first Item D expenses for May, June and July in August of $15, $10, and $25 respectively. This actual Item D determination is processed in August.

May	15
June	10
July	25
	50 divided by 3 = $16.67 month effective Sept., Oct., Nov.

At the redetermination in November (third month of projected quarter), the following expenses are reported for the previous three months:

Actual			Projected		
August	20.00		August	0	
September	10.00		September	16.67	
October	5.00		October	16.67	
	35. 00	Actual		33.34	Projected
	- 33.34	Projected			
	1.66	Difference			
	35.00	Actual			

36.66 divided by 3 = 12.22 month effective Dec., Jan., and Feb.

EXAMPLE #2: Item D (Re)determinations

At the second redetermination in February, the following expenses are reported for the previous months:

Actual			Projected		
November	0		November	16.67	
December	5.00		December	12.22	
January	10.00		January	12.22	
	15.00	Actual		41.11	Projected
	41.11	Projected			
	26.11	Difference			
	+ 15.00	Actual			

- 11.11 divided by 3 = $0 month effective March, April, and May

EXAMPLE #3: Item D (Re)determinations

During the third redetermination in May, Mr. A. reports these expenses:

Actual		Projected	
February	5.00	February	12.22
March	15.00	March	0
April	0	April	0
	20.00		12.22
	- 12.22		
	7.78		
	20.00		

27.78 divided by 3 = 9.2 month effective June, July, and August

Item Ds which Exceed Income

When the projected Item D is greater than the individual's income, deduct only the amount equal to the available income. The Item D amount in excess of the income is considered a liability overcharge to be deducted at a future time when there is income to deduct it. Liability overcharges are not subject to the adjustment to actual process.

EXAMPLE:

Patient Liability Budget			Computations
Gross Income	$280	80	Actual Monthly Item D
Minus PNA	- 40	- 55	Budgeted Item D
Remainder	240	25	Monthly Excess Item D
Minus spousal/ Dep. Allocation	- 150	x 3	
Remainder	90	75	Quarterly Liability Overcharge to
Health insurance	- 45		be budgeted when there is
Remainder	45		deduction of Item Ds in the "Patient
Minus Item D	55		Liability" budget.
Patient Liability	0		

If Item Ds cannot be adjusted in future months due to death or discharge, see below.

Correction of Patient Liability Overcharge Errors

When a Patient Liability error occurs which results in a client overcharge,

- Complete a patient liability overcharge adjustment for a future month(s) if the client has enough income to adjust in the next month's patient liability OR

- Send in a "correction" 2362 for the month in question provided it is not for an adjustment more than 24 months prior to the processing month.

Document the electronic case record regarding the overcharge (how, when, why and how much) and how it is being adjusted. Adjust the overcharge the next effective month if the entire adjustment can be made in one month. If not, a 2362 with "correction" written at the top of the form should be completed for the month(s) the overcharge occurred.

Patient liability overcharges subject to an adjustment include agency errors and retroactive reduction in VA A&A to $0.

Item Ds for Month of Discharge/Death

In closing out vendor eligibility, the last month's patient liability must be redetermined to include Item Ds not preciously counted. Item Ds incurred for months not used in the latest Item D redetermination and those projected months occurring after the month of death/discharge are added to the projection for the month of death/discharge. The total is the amount to be deducted as an Item D in the month of death/discharge.

No adjustment to actual is made during this time as this is a final accounting of all unused Item Ds including those Item Ds for the month of discharge/death that could not be used previously because patient liability was zero (i.e., patient liability overcharges as illustrated above). Any additional Item Ds that cannot be offset by the client's income in

the last month of institutionalization may be processed as correction of a patient liability overcharge as indicated above.

EXAMPLE: Mrs. Maxell was discharged on October 3. She had Item Ds projected of $40 a month for October, November, and December (using expenses incurred in June, July, and August and processed in September). Expenses incurred in August of $15 and $20 in September which were not used plus the $40 each November and December are added to the $40 projected for October to determine the final Item D deduction.

	$15	August unused Item D
	20	September unused Item D
	40	October projected Item D – not used
	40	November projected Item D – not used
+	40	December projected Item D – not used
	155	Total Item D deduction for October

RESOURCES

INTRODUCTION

Policy Statement

This chapter applies to all categories of TennCare Medicaid eligibility, including Institutionalized Individuals.

Individuals who apply for TennCare Medicaid are allowed by Federal Regulation and Tennessee State Law to retain some assets to meet their needs subject to certain limitations. Those individuals who are found to have resources in excess of these statutory limits are ineligible for benefits. It is the Legislature's intent that the resources in excess of the limits be used by the individual to meet medical needs before turning to the TennCare Medicaid program for assistance. In an effort to prevent individuals from resorting to liquidation of all their assets, especially any real property used as a homestead, the law provides a liberal exemption to certain assets.

Public Law 96-611 and the Tennessee Code Annotated provide that the value of certain transferred assets is considered to be a countable asset, that is, considered a liquid asset to which the individual has access and as such, it is counted along with other non-exempt resources subject to the applicable resource limit. The value of the transferred asset continues to be considered an available resource for a specific period of time based on the amount for which the individual was uncompensated in the exchange.

Definitions

- Resources

  Resources mean cash or other liquid assets or any real or personal property that an individual owns jointly or individually that could be converted to cash and used for support and/or maintenance.

  Resources are those assets the individual has on hand at the beginning of the month as opposed to income which is any cash, wages, pensions or other funds received during the month. If these two distinct items are mingled, as in an individual's bank account, maintain a distinction between assets and current income in the eligibility determination process.

- Available Resources

  Resources available to the client include those for which he has the right, authority, ability, or power to liquidate including those deemed available to him from a FRR and the uncompensated value of a transferred asset.

The owner's incompetence, whether presumed or actual, does not bar the person's legal authority to withdraw his or her savings in the situation where a conservator or guardian, or someone acting on the person's behalf, has not been legally appointed. A bank's refusal to accept a variation of the signature under which an account was established is not regarded as a legal barrier to the use of the funds. However, if an individual is legally prevented from having access to the funds, the funds may not be considered a resource.

DETERMINING RESOURCE ELIGIBILITY

Resource Limits

Resource limits vary according to the TennCare Medicaid category of eligibility.

- Families First-related eligible groups

  For Families First-related eligible groups: Medicaid Only (AFDC-MO or 1931 Eligibility), MA P Pregnant Women, and MA S, Sibling Income, the resource limit is $2000 for the budget group.

- Institutionalized Individuals

  For institutionalized individuals, the limit for an individual is $2000 in countable assets and for a couple $3000.

- Poverty Level Pregnant Women and Children of a Specified Age, MA N Newborns

  For Poverty Level Pregnant Women and Children of a Specified Age, MA N Newborns, resources are not considered in determining eligibility.

- Medically Needy MA T

  For Medically Needy MA T coverage for pregnant women and children only, the limit is $2000 for one person, $3000 for two persons, and add $100 per additional individual.

- SSI Pass Along/Pickle

  For SSI Pass Along/Pickle cases, the limit is $2,000 for an individual and $3,000 for a couple.

- QMB, SLMB, Q

  For QMB, SLMB, QI categories, the limit is $4000 for an individual and $6000 for a couple.

A quick reference is also available on the DHS intranet web site at the Desk Guide which can be accessed at **www.intranet.state.tn.us/dhs/desk-guide.pdf**.

When to Evaluate Resource Eligibility

The individual is resource eligible when the amount of the countable resources held by the aid group is at or below the applicable resource limit at any time during the month under consideration.

The total amount of resources may fluctuate throughout a month and the aid group may have assets in excess of the reserve limit at any point during the month and attain resource eligibility, if the total amount of assets declines to an amount within the limit at some point during the month.

If the value of the individual's resources is greater than the resources reserve limit for the entire month, he is not resource eligible that month. The earliest he may be determined resource eligible is the next month if resources equal or are below the limit any time during that next month.

Resource Eligibility at Application/Redetermination

Self-declaration of resources may be used for applicants/recipients who apply for TennCare Medicaid in any of the family and children's coverage groups. Verification is not required unless the information provided is questionable.

For all other categories of TennCare Medicaid, do not verify liquid resources if the individual alleges total countable resources of $1000 or less, and less than $500 of that total is liquid resources.

Do verify the actual amount of all liquid resources where the total of the alleged liquid resources is more than $500. Cash counts towards the $500 figure but do not verify the amount of cash alleged. An individual is resource eligible at application when the value of the countable resources falls at or below the resource limit any point during the month under consideration including month(s) in the retro period (institutionalized individuals only).

The caseworker must set an Expected Change at a reasonable time period (not to exceed every 3 months) to review resource eligibility if the aid group is determined to be within $100 of the applicable resource reserve limit. At redetermination, do not verify liquid resources if the alleged amount of liquid resources is $1250 or less at the time of the redetermination interview or completion of the redetermination review.
Resources, except for cash, are evaluated according to their equity value. Equity value is equal to the current market value of an item less the amount of any encumbrance, i.e., the amount the individual owes on the item. Current market value (CMV) is the price the item would bring on the local open market.

Countable Resources

Countable resources are all those available assets whose value is considered in determining resource eligibility including the value of deemed resources and the uncompensated value of a transferred asset.

Countable Resource Rules

Count the resources of the following individuals:

- The resources of all persons included in the budget group, AND
- The resources belonging to the FRR of the budget group members if the relative and group members are living together at the time.

EXCEPT FOR resources owned by:

- A family member who receives SSI;
- A stepparent; or
- The individually owned resources of the spouse of a budget group member who is not a budget group member.

Resources belonging to the individual's FRR are considered available to him during the month(s) when deeming applies and are counted along with his own individually and/or jointly owned assets to determine resource eligibility. Refer to the section "Deeming of Resources" in this Chapter.

Countable Resources includes all resources that meet the following criteria:

- Resources not excluded by law.
- Resources the client owns individually or jointly with another person.
- Resources deemed to him from his spouse.
- Resources considered available to the individual.
- The uncompensated value of any asset transferred within the 36 or 60 months, as applicable, immediately proceeding the application month.

Liquid Assets

The following is a list of the types of countable liquid assets:

- Cash and bank accounts, including cash on hand, checking account, savings account, certificate of deposit, saving certificate.

- Savings bonds

- Stocks, bonds, and mutual fund shares

- The cash surrender value of IRA and Keogh accounts, minus any penalty for early withdrawal. If retirement benefits are being received out of such accounts, the principal is not considered a resource. NOTE: If the assistance unit can establish that the IRA and/or Keogh account is inaccessible, do not count as a resource. For example, this type of account may not be accessible if it was established in trust for a minor child.

- Revocable burial agreements or life insurance benefits assigned to a funeral home for institutionalized adults only. This resource is excluded for family and children's categories of TennCare Medicaid.

- Lump sum proceeds

- From an estate settlement

- Sale of property other than homestead.

- Non-recurring lump sums are counted as resources in the month received and thereafter if retained: income tax refunds and rebates, money received from Earned Income Tax Credits, if retained, is a countable resource beginning the third month from the month of receipt. Also, security deposits, rental property, or utility refunds.

- Any lump sum payment not included here is considered income in the month received. (Refer to the Income chapter of this Manual.)

- Non-cash death benefits including gifts and inheritances, the second month after the month of receipt.

- Cash death benefits received as repayment of medical and social services already paid, including gifts and inheritances, the second month after the month of receipt.

- The value of a prepaid revocable burial arrangement for adult categories only.

- The value of a Patient Trust Account.

- The value of a mortgage, loan, or promissory note held by the client.

- The cash surrender value of life insurance owned by the individual if the total face value is more than $1500 for adult categories only.

- Prepaid institutional care.

- The value of replacement resources after their exemption expires.

- Amount of lump sum remaining after the month of receipt.

Non-Liquid Resources

The equity value in all unexcluded non-liquid assets is a countable resource. The following is a list of types of non–liquid assets:

- Equity value in excess of $4600 on the first motor vehicle and the and the equity value in all other licensed and unlicensed vehicles for at-home individuals. For

institutionalized individuals, please refer to the section in this Chapter on Motor Vehicles.

- Buildings, land (not excluded as homestead) and unexcluded burial plots for institutionalized individuals only.

- Income-producing property other than homestead.

- Mobile homes not excluded as homestead.

- Recreational vehicles including boats, motorcycles.

Excluded Resources

Overview

The following is a list of the types of resources excluded by law or program policy. More detailed policy and procedures for most items is included in this Chapter.

- **Real property** - Homestead property (home and adjoining land) or Indian lands

- The **full value of one automobile** (under certain conditions) or up to $4600 equity value if not fully excluded.

- **Burial agreements** for each household member, irrevocable or revocable, for the family and children's categories of TennCare Medicaid. For all other categories of TennCare Medicaid: A revocable burial fund reserve valued up to $1500 each for only the applicant/recipient and his/her spouse (family members are not included for this exclusion). The value of an irrevocable prepaid burial trust or agreement established by the applicant/recipient up to $6000 plus any interest accrued thereon and cost transport for the individual and his/her spouse only. Irrevocable burial trusts or agreements established by the funeral home/director are excluded if the cost does not exceed fair market value of merchandise and services. The burial trust must be itemized.

- Burial spaces - Exclude the value of burial spaces, crypts, mausoleum, urn or other repository, including markers, headstone and opening and closing of the grave for the family and children's categories of TennCare Medicaid.

  For all other categories of TennCare Medicaid, the value of burial spaces and the interest accrued thereon, intended for use by the institutionalized individual, his/her spouse, and any number of his/her immediate family.

- **Life insurance** - For family and children's TennCare Medicaid categories only: Exclude the value of all life insurance policies owned by applicant/receipts for each household member. This includes any cash value they may have accumulated.

For all other categories of TennCare Medicaid, life insurance assigned to the client's estate as beneficiary when the will has provisions which provide that the proceeds will be used only for burial expenses.

For all other categories of TennCare Medicaid, the cash surrender value of life insurance if the total face value is $1500 or less.

- **Burial policies** purchased from a funeral home for burial purposes which have no cash value are excluded as resources.

- **Death benefits**, including gifts and inheritances, are not a resource for one calendar month following the month of receipt. If retained the second month following the month of receipt, the benefits are resources. This does not apply to cash received as repayment for medical or social services bills an individual has already paid. That cash is a resource in the month following the month of receipt.

- **Payments or benefits provided under other Federal statutes**, if these payments are not commingled with other funds. This includes: Disaster Relief Assistance received under the Disaster Relief Act of 1974, payments made under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

- **SSI/SSA lump sum retroactive payments** are excluded for 6 months after month of receipt.

- **Household goods and personal effects** with an equity value of $2000 or less.

- The **proceeds from the sale of a home** are excluded to the extent that the funds are intended to be used to purchase another home subject to the homestead exclusion, AND the funds are used for such a purpose within 3 months of the date of receipt of the proceeds.

- **Property essential to self-support**, both business and non-business.

- The **cash or in–kind replacement of lost, stolen or destroyed excluded resources** for up to 9 months from the date of receipt. Interest earned from these funds is also excluded.

- The value of any **asset that has been determined to be unavailable** to the individual.

- The value of and **interest on IRA (Individual Retirement Accounts) and Keogh accounts** only if the individual must terminate employment in order to file for the retirement fund. These accounts are excluded also in deeming from an ineligible responsible relative.

- IRAs, Keogh, and 401Ks valued up to $20,000 or less are not counted as resources in family and children Medicaid categories. If the amount of money in IRAs, Keogh plans and 401ks is more than $20,000, only the amount in excess of the $20,000, minus penalty for early withdrawal, is a countable resource.

- German reparation payments made to individuals because of their status as victims of Nazi persecution are to be excluded as a resource.

- Resources belonging to a FRR who is an SSI recipient.

- Resources belonging to a stepparent, when the natural parent is absent and the stepparent is included for coverage.

- Individually owned resources of a spouse of a budget group member who is not a part of the budget group.

- Equipment used in a self-employment enterprise for producing income.

- Prorated money already counted as income.

- Earned Income Tax Credits are excluded as a resource for the month of receipt and the following month. If retained the third month or thereafter, treat as a resource.

- Crisis Intervention Program payments.

- Domestic Volunteer Service Act.

- Energy Assistance payments.

- Indian/Native American Claims or payments.

- Relocation Assistance payments.

- Student grants and loans to undergraduate students made or insured under any program administered by the Commissioner of Education under the Higher Education Act (PELL grant, SEOG, NDSL, Guaranteed Student Loan, State Student Incentive Grant).

- Youth Employment and Demonstration Act.

- Livestock and poultry consumed as home produce.

- Food program benefits.

Retention of Exclusion Status

Commingled funds

- Excluded funds commingled with unexcluded funds retain their exclusion status for six months from the date they were commingled. After six months, all funds in the commingled account are countable assets, if they are accessible.

  Resources excluded as prorated income and commingled in an account with unexcluded funds retain their exclusion status for the period of time over which they have been prorated as income. This period may extend longer than six months. At the end of the proration period, any accessible funds the client retains are counted as resources.

- Excluded resources kept in a separate account that are not commingled with other (non-excluded) funds retain their exclusion status for an unlimited period of time provided that the applicable exclusion provisions are observed.

Burial Reserve

Burial agreements whether revocable or irrevocable are excluded as resources for the family and children's categories of TennCare Medicaid. This applies to the applicant/recipient as well as each household member.

- The value of certain liquid assets identified by the individual in all other categories of TennCare Medicaid as burial funds is excluded in determining resource eligibility. Individual burial funds up to $1500 each for the individual and his/her spouse ONLY may be excluded from countable resources.

  During a deeming month, the individual and his spouse may each have a maximum of $1500 excluded as part of a burial reserve. The $1500 maximum limit is reduced by other burial assets the individual owns. See the section "Determining the Amount of the Reserve". Burial funds may not be set aside for any relatives except the applicant/recipient and his/her spouse, if the spouse's income is deemed to the client or they are applying as an eligible couple.

- Burial Funds are defined as burial arrangements, cash, accounts, or other financial instruments (documents which have a definite cash value) which are clearly designated for burial expenses.

  These funds must not be commingled with other resources. For example, burial funds in a bank account must be kept separate from an individual's other savings; i.e., a different account must be established for the burial funds.

  For applications, burial funds which are commingled with other resources may not be excluded. If funds are uncommingled prior to approval, the exclusion may be allowed. Uncommingled funds may be designated retroactively.

For active cases with burial funds commingled with other resources, clients will have until the end of the month after the month of redetermination to separate these funds.

Active cases who have burial funds excluded which do not meet the new, more restrictive definition of burial funds must convert these funds to meet the new definition by the month following the month of redetermination.

For both commingled funds and funds not meeting the new definition of burial funds, if an impediment exists preventing the conversion or separation of funds, these existing burial funds will continue to be excluded if the individual remains otherwise continuously eligible for the exclusion.

EXAMPLE: One acre of land in a four acre tract has been designated as burial asset. In attempting to sell the acre so that it may be converted to an asset which meets the definition, the family discovers that zoning regulations prohibit the subdivision of the four acre tract. We may continue to exclude the land as a burial asset as long as the impediment exists.

- Determining the Amount of the Reserve

The law allows a maximum reserve amount of $1500 reduced by the following burial asset:

The amount of the funds held in an irrevocable burial trust or contract or any other irrevocable arrangement which is available to meet the individual's burial expenses.

The value of any remaining funds (after the deduction of the item above) is the amount of the burial reserve and is excluded from countable assets.

$1500	Maximum Burial Reserve
- (minus)	Value of Irrevocable Arrangement and/or
Result =	Amount of Burial Reserve

The value of any burial funds in excess of the $1500 maximum (or the post-reduction amount) is considered a countable asset.

$1500	Maximum Burial Reserve/Reduction Maximum
- (minus)	total value of burial funds
Result =	Countable Asset

- Applying the Burial Reserve Exclusion

Determine the individual's resource eligibility. Apply the burial reserve exclusion. Up to $1500 per person shall be excluded, if separately identifiable and set aside for the burial expenses of the individual and/or spouse.

- Identifying Burial Funds

  In order to exclude funds as part of the burial reserve, the funds must be identifiable by segregation in a separate bank account or other instrument no later than the disposition date of the application (i.e., before application can be approved, the funds must be segregated). A statement may be obtained indicating the month in which the client first intended for these funds to be set aside for burial. Designated burial funds may be excluded retroactive back to the first day of the month in which the individual intended the funds to be set aside for burial provided the statement confirms such intention.

  Burial funds can be identified by the following types of documentation. NOTE: This list is not all inclusive.

  - Personal record, including a will, specifying the value of funds intended for burial expenses and their current location, e.g., bank account number.
  - Institution accounts including revocable burial agreements/arrangements with a funeral home.
  - Client's statement regarding location, value and intended use of funds for which exclusion is requested.

    NOTE: Form HS-1306 may be used for this purpose and is available through Shared Base Documents, though "designation" and "segregation" are not exclusion criteria.

- Excluded Value

  Exclude as a countable asset any increase in the value of excluded burial funds due to the accumulation of interest since 12-31-82 OR since the individual first became TennCare Medicaid eligible, whichever is later.

  This interest may be excluded as long as a case is active. A case which closes and later reapplies, must have the full value of the asset, including the accrued interest, considered when evaluating for burial exclusion (i.e., if the principal of the burial funds plus interest is over the limit, the excess is considered a resource). For example, the applicant has $1500 burial plus $200 interest at time of reapplication. The $200 interest is considered a countable resource at reapplication but would have been excluded if accumulated during the receipt of TennCare Medicaid.

  The value of a burial reserve loses its exclusion if any portion of the principal and accrued interest is used for any other purpose than to meet the individual's burial expenses. The exclusion ends effective the first day of the month following the month the burial reserve funds were transferred or encroached upon in any way except for the purpose for which they were excluded.

Conversion of Resources

The exchange of an asset from one form to another while retaining ownership is a conversion of resources. Upon conversion, evaluate the individual's current resource eligibility to determine if he exchanged a previously excluded resource for one which is countable, thus affecting the total value of his countable resources.

DEEMING OF RESOURCES

Legal Base: 20 CFR 416.1260 – 416.1269

Institutionalized Individual effective 10-1-89 or Later

Resources belonging to the individual's FRR are considered available to him during the month(s) when deeming applies and are counted along with his own individually and/or jointly owned assets to determine resource eligibility.

Deemed resources are considered available assets during the period when deeming applies whether or not they are actually available to the individual.

Resources Excluded from Deeming:

The resources deemed from a FRR are subject to the exclusions cited earlier in this Chapter and discussed in more detail throughout the Chapter, except that the resources belonging to the FRR are deemed to the individual whether or not they are actually available to him.

In addition to the above exclusions, pension and retirement funds owned by an ineligible FRR are excluded from countable resources for deeming from the ineligible spouse to the eligible individual. Retirement funds include annuities or work-related plans for providing income when employment ends (e.g., pension, disability or retirement funds administered by an employer or union). Funds held in individual retirement accounts (IRA) and Keogh are retirement funds also. Profit-sharing plans established by an employer may also qualify.

Spouse to Spouse Deeming

Ineligible Spouse

The ineligible spouse's separately owned resources are considered available to the eligible individual during a month when deeming applies. Deeming applies during the time the couple lives together in the community.

Under Spousal Impoverishment (SI) provisions, eligibility for the institutionalized spouse (IS) will be based on both of their (IS and CS) countable resources, regardless of any prenuptial agreements, for the initial month of eligibility. Once the IS is determined eligible, the CS

resources are no longer taken into consideration beginning the month following the initial month of ineligibility.

Also, under SI provisions, if the CS applies for TennCare Medicaid during the month of his/her spouse's admission to a long-term care facility, the CS is considered as an individual. None of the IS's income and resources is considered in determining the CS's eligibility. On the other hand, resources of the CS are taken into consideration in the assessment of resources and in determining the initial month of eligibility for the institutionalized individual.

NOTE: The individual in HCBS in the home is considered institutionalized in determining his/her TennCare Medicaid eligibility. However, TennCare Medicaid eligibility for the CS is determined using deemed income and resources from the HCBS spouse.

When there is an eligible individual with an ineligible spouse whose resources are to be deemed, combine the eligible individual's resources with those of his ineligible spouse, apply the exclusions cited previously in this chapter, and exclude the value of the ineligible spouse's retirement funds as defined above, including IRA or KEOGH accounts. Compare the remaining countable resources to the resource reserve limit for a couple. The individual is resource eligible if the combined countable resources are no greater than the resource limit for a couple.

Eligible Couple

The separately owned resources of the eligible couple are considered mutually available to each other during the time the couple lives together whether or not they are actually contributed. The couple is treated as separate individuals beginning with the month after the month of separation or the month of separation if either spouse files an application for TennCare Medicaid, see exception noted above.

Spousal Impoverishment for Institutionalized Individuals – 9/30/89 And After

The Medicare Catastrophic Coverage Act of 1988 allows a more liberal treatment of the resources of the individual and the spouse of the resident in a long–term care facility or HCBS facility (i.e., the community spouse) to keep a larger amount of assets when the institutionalized individual applies for TennCare Medicaid. Long term care and HCBS providers are required by that law to notify all residents who are admitted to the facility/HCBS care on or after September 30, 1989, of their right to request an assessment of their assets and the assets of their community spouses. The facility/HCBS provider must inform all residents, their spouse and/or representative orally and in writing that they may request an assessment of their resources by contacting the local DHS office.

The resource assessment is required for all institutionalized individuals with a legal spouse living in the community whose whereabouts is known.

The CS who does or does not receive FF, Food Stamps, SSI, TennCare Medicaid, VA pension, QMB or other needs-based assistance has the option to accept or decline all, some or none of

resource allocation from the institutionalized individual if the allocation would cause loss of or decrease in those benefits. If the CS accepts some of the resource allocation, the remainder of the resource continues to be considered as the institutionalized spouse's resource.

The spousal resource allocation may be allowed if a couple is still legally married but living separately and considering themselves as separated if the whereabouts of the CS is known or can be located.

If the CS lives out of state, the resource allocation/assessment is required if the CS can be located and the couple is still legally married.

Resource Assessment Request for Institutionalized Individuals

Request Time Frame

The resource assessment may be requested whether or not the resident is applying for TennCare Medicaid at the time of admission. Generally, it may be to each spouse's benefit to have the assessment done at the time of admission, even if no concurrent application for TennCare Medicaid is made, since the availability of documentation at this time may result in the protection of a greater amount of assets for the CS. If the request for the assessment is delayed until the time of application, the assessment will be done retroactively to the time of admission, but the results may be limited by the availability of documentation. When a TennCare Medicaid application is made, the results of the assessment are used as part of a formula to determine how much of the total assets may be protected for the CS. The remaining resources after allocation to the CS are considered available to the institutionalized individual.

If it is discovered at application, or at any time after the assessment is completed, that not all resources were reported or known, the assessment is recalculated. Resources available at the beginning of the period of institutionalization, regardless of interruptions of confinement in long-term care, must be reconstructed and documented.

Transfer of assets is not considered at the time an assessment only is requested (i.e., no TennCare Medicaid application filed concurrently).

Longevity of Assessment

An assessment remains in effect until application is made, regardless of any interruptions in long-term care.

Application Filed at Assessment Request

When an assessment is requested, please advise the client or his/her representative that he/she must provide all necessary documentation and verification timely to ensure that an accurate assessment can be completed within a reasonable amount of time (i.e., 30 days from date all required documentation is received).

If it is discovered at application, or at any time after the assessment is completed, that not all resources were reported or known, the assessment is recalculated. Resources available at the beginning of the period of institutionalization, regardless of any interruptions of confinement in long–term care, must be reconstructed and documented.

Transfer of assets is considered as a part of the application process whether or not a resource assessment has been requested previously or is requested at the application.

Procedures

The total countable resources of both spouses are combined and then divided by two (2). The highest of the following will be considered available for the CS:

- ½ of the total, not less than $20,880 or greater than $104,400 as of January 1, 2008 OR THE
- Court-ordered amount, OR THE
- Amount determined by an appeals hearing officer due to a hardship situation (extreme financial duress).

NOTE: The most up-to-date spousal allocation resource limits can be found by reviewing the Desk Guide available at www.intranet.sate.tn.us/dhs/desk-guide.pdf.

When an application is filed by or on behalf of the institutionalized individual, the amount determined in the assessment will be the amount allocated to the CS (item 12A on Form HS-2510). This amount will be deducted from the combined resources of both spouses as of the first day of the first month for which assistance is requested. If the institutionalized individual is eligible, none of the CS's share of resources is considered available to the institutionalized individual in determining his/her eligibility for TennCare Medicaid after the initial month of eligibility.

EXAMPLE: The combined resources of Mr. and Mrs. Revco (he is institutionalized) totaled $31,000 divided by 2 = $15,500 ($20,328 minimum). Consequently, Mrs. Revco's share of the total resources was determined to be $20,328, the minimum resource allocation. This leaves $10,500 available for the institutionalized spouse. When total resources do not exceed $20,328 Mr. Revco will be resource eligible.

$20,500	total remaining resource as of the 1st day of the 1st month assistance is requested
-20,328	community spousal share from assessment
$ 192	available to institutionalized who is now resource eligible

Resource Transfer as Result of Assessment

Following an assessment and approval of the application, resources must be transferred if necessary within a "practicable" amount of time (12 months from approval). Both spouses must agree to the transfer prior to the first eligibility review (usually 12 months) in order to use the institutionalized spouse's share in determining his/her eligibility. The transfer may require conveyance of resources from the institutionalized to the community spouse or from the CS to the institutionalized. The CS who receives SSI, FF, VA pension, TennCare Medicaid or other benefits does not have to accept the total resource allocation if it will result in termination of benefits.

If the resources determined available to the institutionalized exceed the $2000 resource limit plus up the allowable burial reserve, the institutionalized individual will not be eligible until resources are within allowable limits.

Transfer (Required by Assessment) Refusal

When the CS refuses to transfer resources to the institutionalized, the institutionalized individual will not be ineligible on the basis of those deemed resources if hardship conditions are found to exist as the result of an appeal hearing decision.

Hardship

Hardship in this instance may be considered to exist when the institutionalized spouse and/or his/her spouse have no resources in excess of the resource limit, is otherwise eligible, and for whom TennCare Medicaid ineligibility will result in loss of essential nursing care which is not available from any other source.

If the CS has available assets, he/she is legally obligated for support; therefore, hardship does not exist unless assets have been reallocated as the result of an appeal decision or a court order.

Appeals

Appeal Rights are considered only after an application for assistance has been filed and either spouse alleges that the assessment or eligibility determination decision is not correct. An assessment completed exclusive of a filed application cannot be appealed. Revisions to the spousal allowance of resources can be made by the appeals officer or by court order (or by the DHS caseworker ONLY if additional verification/documentation is provided).

The appeals officer may determine a larger CS share for resources is necessary to raise the income to the minimum standard maintenance (SMA) amount because of "exceptional circumstances due to financial duress". This means that if the amount of income allocated to the CS is not sufficient to meet the basic standard maintenance amount, and there are available resources, an additional portion of the institutionalized's resources can be allocated to the CS to bring income up to the SMA.

The Deficit Reduction Act (DRA) 2005 required all States to allocate the maximum amount of available income of the institutionalized spouse to the community spouse before granting an increase in the community spouse resource allocation. Tennessee currently uses this income first method.

In cases where a community spouse is seeking an increase on the basis that additional resources are needed to generate the monthly maintenance needs allowance; please complete the income allocation first as outlined in Chapter 3 of this manual.

1. Transfer of Assets

   A Transfer of Assets for less than fair market value is not considered to have occurred when resources are transferred from the institutionalized to the CS or vice versa in accordance with a completed resource assessment. This also holds true for any spouse-to-spouse transfers that take place after 9-30-89. There will be no penalty applied for transfers between spouses after that date.

   Should the transferred-to spouse then transfer the resource to someone else for less than fair market value, the transfer will be treated as a transfer of assets by the institutionalized individual.

   Transfer of assets for less than fair market value is considered as a part of the application process whether or not a resource assessment has been requested previously or is requested at application. Transfer of assets is not considered if a resource assessment ONLY (no TennCare Medicaid application filed concurrently) is requested.

2. Inactive Applicants

   Assessments completed for individuals not currently applying are to be filed in individual case folders and kept in a specified secure area. Send a copy of the completed assessment to the TennCare Medicaid Policy Unit in the DHS state office for control purposes. A master file is to be maintained in the State Office for access by the county offices, as needed, when cases transfer to other counties or caseload adjustments cause assessments to become misplaced.

AVAILABILITY OF ASSETS

Policy Statement

Countable resources include only those resources actually available to the individual or the budget group members. The cash value of resources which are not currently accessible to him or which cannot reasonably be brought to a condition of current availability are not counted with other resources in determining his resource eligibility. However, a promissory note, loan

or mortgage that is not actuarially sound would be a countable resource as referenced in the DRA of 2005.

The owner's incompetence, whether presumed or actual, does not bar the person's legal authority to withdraw his or her liquid resources in the situation where a conservator or guardian, or someone acting on the person's behalf, has not been legally appointed. A bank's refusal to accept a variation of the signature under which an account was established is not regarded as a legal barrier to the use of the funds. However, if an individual is legally prevented from having access to the funds, they may not be considered as a resource.

There are **exceptions** to the available assets rule:

- The uncompensated value of an asset transferred within 36 months, as applicable, of application or eligibility redetermination is counted.

- Resources deemed from a financially responsible relative (FRR) are counted regardless of their actual availability to the individual unless the asset is unavailable to the FRR.

- Resources belonging to the child's FRR with whom he lives are considered available to him regardless of actual availability unless the asset is unavailable to the FRR.

Assume the individual's or budget group's resources are available unless one of the following conditions exists:

- Inability to sell an asset due to limited use rights, the client's mental impairment, or the conditions of joint ownership.

- Inability to locate a buyer for the asset.

- The value is unavailable due to a lien against the asset.

- The asset's value is not accessible to the client due to litigation.

Inability to Sell an Asset

The equity value of a non-liquid asset is not available to the client unless he is free to sell it. Exclude the equity value in resources that he is unable to sell for one of the following reasons:

Limited Use Rights

If the client has only limited use rights to a piece of real property such as lifetime occupancy or dower rights, he is not able to sell the property; however, he can sell his use rights.

Exclude the equity value due to inaccessibility in determining countable resources if the client can demonstrate unsaleability by providing written statements from two licensed real estate agents substantiating that, in their professional opinion, the life estate (or other use rights arrangement) is unsaleable.

NOTE: Document thoroughly the verbal statements of those in a position to know if they refuse to give a written statement or to sign a written statement.

Client's Mental Impairment (applicable to non-liquid resources only)

If the client has a guardian, conservator, power of attorney or durable power of attorney at the time of application/redetermination, the assets of the client are considered available to the client. That person is legally appointed to act in behalf of the client and is expected to make the client's assets available for use by or for the care of the client.

If the client's mental impairment precludes his negotiating the sale of an asset, and he has no guardian or conservator to act in his behalf, exclude the asset as unavailable under certain conditions. It is not necessary that the client be adjudicated incompetent by a court of law. If, in the caseworker's opinion or that of the responsible party or person in a position to know the facts of the client's situation, the client is mentally impaired, apply the provision of this policy.

- Client's Mental Impairment at Application

  Temporary Exemption - Exclude the asset as unavailable for up to 3 months from approval date if the client or the person applying in his behalf agrees to the following:

  - Take steps to be appointed guardian or to contact the client's friends and/or relatives regarding their willingness to serve as the client's guardian/conservator;

  - See that the individual who agrees to serve takes immediate steps toward appointment; AND

  - To provide DHS with substantial documentation of his action and that of the guardian designee.

  If the client or responsible party is unable to perform the above-cited tasks, he must provide the names and addresses of individuals who might be willing to serve as the client's guardian. The DHS caseworker accepts the responsibility for contacting the named individuals in an effort to locate someone willing to act as guardian.

  Contact each of the individuals by telephone or by mail explaining the situation and requesting their assistance in securing a guardianship for the client for the purposes of making available assets which the client needs to meet his medical needs. Document the case thoroughly.

The following contains instructions for the period following the expiration of the temporary exemption.

Long-Term Exemption - An asset may continue to be considered unavailable beyond the initial three-month period until the next redetermination under the following conditions:

- No guardian is found

  If, after three months, the efforts of the caseworker and the person acting in the client's behalf have failed to locate a potential guardian, document the case record establishing the asset's inaccessibility. If the client is otherwise eligible, continue assistance. Extend benefits during the retro period if all of the following conditions are met:

  - the client requested benefits for that period;
  - the same conditions regarding the disputed asset existed at that time; AND
  - the client is otherwise eligible.

  Upon approval of the case, notify the Bureau of TennCare of the client's unavailable asset. Send written notification to the Program Integrity Unit of the following:

  - client's name
  - client's TennCare Medicaid ID number
  - client's address
  - description of the asset including its FMV and the client's equity value
  - date DHS determined it as unavailable and excluded its value as a countable resource.

- Potential Guardian is Found

  Exclude the asset for an additional 30 days from the date the potential guardian agrees to serve to allow him to file a petition for guardianship with the court. If after 30 days the potential guardian has not initiated guardianship procedures for any reason, exclude the resource per instruction above under "no guardian is found".

  If, after 30 days, the potential guardian has begun appointment procedures, continue to exclude the asset as unavailable until the next redetermination.

  Set an Expected Change at regular intervals (every 60 to 90 days) to follow up on the situation and to determine the court's instructions regarding the asset.

NOTE: If it becomes necessary to delay action on an application in order to determine an asset's availability as described in this item, secure the client's written permission to hold the application pending beyond the processing time limits.

- Client's Mental Impairment at Redetermination

  Exclusion Previously Granted - If an asset has previously been excluded as unavailable as described in this item, at least 30 days before the redetermination is due, secure current information to substantiate that asset remains inaccessible because:

  - An individual willing to act as the client's guardian has not been located; OR

  - Guardianship proceedings have begun but are not complete or the court has issued no instruction regarding the disputed asset.

  Initial Exclusion - If the asset has not been previously excluded as inaccessible as described, but since the last review its equity value along with other countable assets results in the client's ineligibility, and the client cannot dispose of the asset due to his mental condition, do not continue to extend TennCare Medicaid benefits until the asset's inaccessibility has been substantiated as described above.

  Take action to close the case observing the adequate and advance notice requirements. Once the asset's inaccessibility is verified and the client has reapplied, benefits may be extended retroactively to the date of closure provided the client is otherwise eligible.

Joint Ownership

If an asset cannot be sold or converted due to the conditions of joint ownership, exclude the client's equity value in determining resource eligibility. The client's equity value in a jointly owned asset can be excluded under the following conditions:

- The resource is jointly owned with a person or persons who are not the client's FRR (i.e., spouse or parent); AND the joint owner refuses to consent to the sale of the asset or to purchase the client's interest.

- Even though the client is free to sell his own individual interest in the property, he is unable to find a buyer.

- For institutionalized individuals, the sale of the jointly owned property would cause the other owner undue hardship through loss of housing.

  NOTE: Any portion of real property owned through "tenancy-in-common" or "joint tenancy" arrangements is available to each owner for sale or transfer without the consent of the other (joint) owner(s).

Policy Implementation at Application - Do not extend TennCare Medicaid benefits until the asset's inaccessibility to the client has been substantiated by the following:

- The co-owner(s) written refusal to consent to the sale of the asset and to purchase the client's share, if applicable.

- Substantiation (by deed or the written statement of a licensed real estate agent or an attorney) that the client is unable to sell his interest in the asset without the consent of the co-owner(s) OR that his individual share is unsaleable.

NOTE: If it is necessary to hold the application pending beyond the processing time limits, secure the client's written permission to do so.

Policy Application at Redetermination - If the asset has not previously been excluded as described in this item, do not continue to extend benefits at review until the asset has been demonstrated to be unavailable as described above. Take steps to close the case observing standard adequate and advance notice requirements. Once the asset's inaccessibility has been verified and the client has reapplied, benefits may be extended retroactively to the date of closure provided the client was otherwise eligible.

At least 30 days before the review is due, secure the joint owner's written statement regarding his position on the sale of the asset and the purchase of the client's share, if applicable. Request that the client present written substantiation of his inability to sell the asset as described above. Continue to exclude the value of the asset if the client's claim of inaccessibility is supported by the joint owner's statement.

Ownership Interest in an Unprobated Estate

If the client has inherited an interest in real property that is part of an estate still in probate, his interest is a countable asset because he can legally sell it. It may, however, be difficult to do so.

Exclude the value of the asset if the client can demonstrate that he is unable to sell his interest by providing statements from two knowledgeable sources, e.g., an attorney or real estate agent, that his interest cannot be sold. The exclusion can be applied to the asset only while it remains in probate.

Extend benefits only after the inaccessibility of the asset is substantiated as described above. Secure the client's written permission to hold the application pending beyond the processing time limits, if necessary. Do not continue to extend benefits until current verification that the asset is unavailable is secured.

Inability to Locate a Buyer

Policy Statement

If the client owns an asset for which he has full use rights and the unrestricted right to sell, and he is making a bona fide effort to sell the resource, but he is unable to locate a buyer, his equity value may be excluded as a countable resource.

Definitions of Terms Used in this Part

Bona Fide Effort to Sell - Real estate: A bona fide effort to sell exists when one of the following conditions is met:

- The property is not saleable due to a specific condition substantiated by the written statement of at least two knowledgeable sources such as licensed real estate agents.

- The property has been offered for sale for at least 90 days (throughout a consecutive 90-day period) and there have been no legitimate offers.

Offered for sale - means listing the property with a licensed real estate agent, advertising the property for sale using at least two alternate methods such as a sign on the property and a newspaper ad in a newspaper that serves the area where the property is located, or placing the property on auction.

Reasonable asking price - means a price that is not inflated, i.e., not in excess of 100% of the real value.

Legitimate offer - means one that is at least equal to the reasonable asking price, does not require the client to extend credit, and does not result in a net loss to the client. No reasonable offer to buy may be refused by the client or his/her authorized representative.

Mortgage or Promissory Note - A bona fide effort to sell a mortgage or Promissory note exists when all the following conditions are met:

- The client has made an effort to offer the instrument to a bank or other financial institution; AND

- The best offer he received is more than 10% below the actual value of the remaining principal; AND

- The client presents written verification from the representative of at least two financial institutions that the mortgage or note could only be sold if discounted by more than 10%.

Policy Implementation - At Application

- Bona Fide Effort to Sell

  Before the exclusion described can be applied to real property, the client must provide substantiation of his bona fide effort to sell for at least one consecutive 90 day period within the immediately preceding 120 days.

  If the property has not been on the market for at least 90 days, obtain the client's written permission to hold the application pending beyond the processing time limit to allow him to fulfill the 90 day requirement. If the property remains unsold at the end of the 90 day period, the asset is considered unavailable and to have been unavailable throughout the 90 day period.

  If the same local economic conditions (or other conditions which prevented the sale) existed prior to the 90 day sale period and the client provides substantiation of these facts, extend the exclusion to include months prior to the first day of the 90 day period.

  Once real property is exempt under the provisions of this policy, it must remain on the market at a reasonable asking price until it is sold OR the client is no longer eligible for and a recipient of TennCare Medicaid benefits.

- Mortgage or Promissory Note

  Before excluding the value of a mortgage or promissory note, entered into on or after February 8, 2006, the repayment terms must be actuarially sound. The actuarial standards to be applied are those determined by the Office of the Chief Actuary of the Social Security Administration (SSA, the table called the Period Life Table can be found on Sosa's Actuarial Publications Standard Table and can be assessed at (http//:www.ssa.gov/OACT/STATS/table4c6.html). The agreement must provide for payments to be made in equal amounts during the term of the loan and with no deferral or balloon payments. It must prohibit the cancellation of the balance upon the death of the lender. If the required criteria are not met, the purchase of the promissory note, loan or mortgage's outstanding balance that is owed at the time of application must be treated as a transfer of assets.

  EXAMPLE: Ms. Jones made an application for nursing home Medicaid on November 8, 2006. She sold her home to her daughter that same day, for $80,000. Her daughter agrees to pay $100 per month for 19 years and 11 months with a balloon payment in the last month of the term loan. Their agreement was notarized by a notary republic. Because this loan was not actuarially sound and had a balloon payment on the end, this loan must be treated as a transfer of asset.

  NOTE: This policy is effective with the release of this bulletin

Exclude the value of the mortgage or note effective the date of application unless the client can establish that the same conditions existed in the retro period. On excluded notes, any payments made by the debtor towards the principle or interest are counted as unearned income to the client in the month of receipt.

If a buyer cannot be found, before excluding the value of the loan or promissory note, the client must provide written substantiation from two knowledgeable sources that the note could be sold only if discounted by more than 10%.

The importance of timely reporting any change of status regarding the sale of the property must be discussed and emphasized with the client or his/her authorized representative. An Expected Change must be scheduled to review the progress of the sale no later than three months from the date the property is placed for sale or from the date of approval if the case continues to be active.

At Redetermination - Bona Fide Effort to Sell

- Initial Exclusion

  If the asset has not previously been excluded for the reason described in this item, do not continue to extend benefits until inaccessibility has been substantiated as described here. Take steps to close the case observing standard adequate and advance notification procedures.

  NOTE: Property cannot be exempt as homestead while it is being offered for sale. A property's exemption as homestead is voided by an attempt to sell it.

- Real Estate

  Once the asset has been proven unavailable, exclude the client's equity value in real estate effective the date it was placed for sale. This will allow any subsequent approval and include benefits retroactively to the date of closure. In order for the real property to continue in its exclusion status, it must remain on the market until it is sold or until the client's case is closed.

- Mortgage

  Exclude the value of a mortgage or note effective the date of the written verification or prior to that date if similar (documented) conditions existed, whichever is earlier.

Asset Previously Excluded

At least 30 days before the redetermination is due, begin the review of asset availability. In order for real property to retain its exclusion under the terms of this item, it must remain on the market until sold or the client is no longer eligible. The client must provide current verification of the following regarding the property:

- The property is advertised for sale using at least two methods of advertisement OR is listed with a broker; AND
- Is listed with a reasonable asking price; AND
- The client has not declined any reasonable offers.

In order to continue exclusion of the unpaid principal on a mortgage or promissory note, the client must provide current (no older than 30 days) verification of his bona fide effort to sell as defined above.

The property must continue to remain on the market for sale until it is sold. Periodic Expected Change actions or reviews must be conducted at least semi-annually for cases in which a "bona fide" effort to sell has been determined. The electronic case record must be updated regularly. Action must be taken to close an active case if it is determined that the property has not met bona fide efforts to sell. This applies to property previously excluded as well as any reported or recently acquired property which has not gone on the market for sale. Action must also be taken to close the case at the point the property is sold, and the proceeds plus other countable resources exceed the allowable resource limit.

Lien

Consider unavailable to the client any portion of real or personal property against which a legal lien has been filed. The equity value in the remaining portion is an available asset. Do not exempt any portion of an asset under the provisions of this item until it is established that the lien is legal, i.e., filed, UNLESS the lien is one pending filing by the Department of Mental Health and Mental Retardation. Deduct the amount of the legal (filed) lien from the client's equity value in the asset to determine the portion that remains a countable asset.

Record the following information regarding the lien in the electronic case record:

- Name of the party filing the lien
- Total amount of the lien
- Filing date
- Place filed

DMHDD Liens.

Exclude as unavailable an amount equal to the amount of the pending lien if written assurance from the DMHDD that a claim will be filed within 90 days is received. Do not extend or continue benefits until confirmation of the DMHDD's intent to file a lien is confirmed.

If a temporary 90 day exemption is extended, set up an Expected Change effective the 90th day. On the 91st day, secure a copy of the lien for the case record. If one has not been filed, discontinue the exemption and consider the entire amount of the client's resources available to him.

Litigation

The equity value of any resource involved in litigation is considered to be unavailable to the client. Litigation means involved in a law suit or some type of court action. Verify with the client's attorney the fact of litigation or secure written documentation that substantiates the client's allegation that the asset is involved in litigation. The asset is considered unavailable to the client effective the date it became involved in the litigation action.

LIQUID ASSETS

Cash On Hand

Cash is money on hand or available in the form of currency or coins. Foreign currency or coins are cash to the extent that they can be exchanged for United States issue.

NOTE: While coin collections may be cash, they are not liquid resources based on their face value but are non-liquid personal effects based on their collector's value. Accept the individual's sworn statement as to the amount of cash he has on hand.

Bank Accounts

The current value of bank accounts (savings, checking, time deposits, etc.,) owned by the individual is a countable asset in determining eligibility. Determine the client's ownership of any type of account in a financial institution including, but not limited to, a bank, savings and loan institution, or a credit union.

In addition to a complete investigation of the individual's bank account ownership allegations, fully explore the possibility of additional accounts including those upon which the individual's name appears solely for convenience, estate, or probate purposes. Ask these questions as they pertain to the individual's circumstances:

- Where do you cash checks?
- Where do you buy money orders?
- Where have you borrowed money in the past 2 years?

- Where do you pay utility bills?
- Where do you pay your home mortgage or rental payment?
- Where do you have checks deposited directly to your accounts?
- Where do you have a special account such as a Christmas Club?
- Where have you obtained bank credit cards such as VISA or Master Card?
- Where do you buy or cash savings bonds?
- Where have you set aside money for a special purpose or for an emergency?
- Does your name appear on any account which you consider to be someone else's?
- Has any account with your name on it been closed within the past 36 months?

Countable Portion

- Single Owner Account

  The portion of the account that is unencumbered as collateral for a loan exclusive of funds representing current income is a countable resource.

- Joint Account

  - Unrestricted Access to Funds

    Family and Children's TennCare Medicaid: The individual with unrestricted access to the entire amount in a joint account has as his countable asset, his pro-rata share of the value of the account. Access to an "and" account requires the signatures of all the owners of the account. Explore the availability of the value of an "and" account when the other owner(s) is a person other than the clients' FRR. If the joint owner(s) is a FRR, the individual's pro-rate share of the entire value of the "and" account is considered available to him as part of his countable assets, subject to the exclusions noted above.

    All other categories of TennCare Medicaid Individuals: The client (or FRR) with unrestricted access to the entire amount in a joint account (an "or" account) is presumed to own the full value of the account. Unrestricted access exists when the individual is legally able to withdraw the funds from the account.

    When two or more eligible individuals have unrestricted access as joint owners of an account (with or without other ineligible owners), each eligible individual is presumed to own an equal share of the total funds in the account regardless of the source of the funds. The eligible individual(s) and/or his responsible party have the right to rebut the ownership presumption. Document the electronic case record to describe the income/resource impact of full ownership of the joint account and the rebuttal provisions procedures.

  - Rebuttal of Ownership Presumption

    If the individual (or FRR) has unrestricted access to the funds in a joint account but does not consider himself to be the owner of the funds either fully or

partially (e.g., the funds deposited by the other owner(s) of the account or the client acts as agent for the other owner) offer him the opportunity to rebut the ownership presumption. At application, allow the individual 30 days to present his rebuttal evidence. At redeterminaton, if counting the full value of the account results in countable resources in excess of the applicable resource limit, take steps to close the case immediately observing all adequate and advance notification procedures and informing the individual of the rebuttal provision. If the individual presents all required rebuttal evidence corroborating his allegation of partial or non-ownership and presumption is rebutted, count only that portion of the account the individual owns as his available asset.

- Rebuttal Evidence

  A successful rebuttal of the presumption of full or partial ownership of a jointly owned bank account includes all of the following evidence:

  - A statement written or dictated by the client (or his/her FRR when deeming applies) giving his allegation regarding ownership of the funds, the reason for reestablishing the joint account, who made deposits to and/or withdrawals from the account, and how withdrawals were spent. If the client alleges he owns only a portion of the funds, he must provide financial institution records, such as a passbook which shows deposits, withdrawals, interest payments, etc. to support his allegation.

  - Statements from the other account owner(s) corroborating statements as described above. If the other co-owner of the joint account is incompetent or a minor, it is unnecessary to obtain that individual's statement. Instead, obtain a corroborating statement form a third party who has knowledge of the circumstances surrounding the establishment of the joint account. If there is no third party, make a rebuttal determination without a corroborating statement.

  - A change in the account designation removing the client's name (or that of the FRR if deeming applies) from the account or restricting access to the funds in the account. If the client alleges he owns only part of the funds in the account in question, he must establish a new account solely in his own name which contains only his own funds.

  - Submittal of the original and revised records as described above substantiating the change in the account designation.

- Restricted Access Accounts

  An individual's access to the funds in an account may be restricted by the legal structure of the account. For example, the following language restricts access to the account to one of the owners: "In trust for John Jones and Mary Smith,

subject to the sole order of John Jones, balance at death of either to belong to the survivor." Only Mr. Jones has unrestricted access. Access to an "and" account requires the signatures of all owners of the account. Explore the availability of the value of an "and" account when the other owner(s) is a person other than the client's FRR. If the joint owner(s) is a financially responsible relative, the entire value of the "and" account is considered available to the client.

- "In Trust For" Accounts

  If the client holds funds in trust for another individual, the entire value of the account is available to him as a countable resource. If funds are held in a trust account for the client, determine who generated the funds. If the trustee of the account verifies the funds in the account are the product of the client's resources or efforts, the entire amount is the client's countable asset. If the trustee verifies that the funds in the account were deposited by someone else, the value of the account is not considered the client's asset. If it is determined that the asset does not belong to the client, thoroughly document the case record.

  NOTE: Do not confuse "In Trust For" accounts with Trust Agreements or Trust Funds addressed in this section.

- Time Deposits

  Time deposits are accounts deposited for a specific period of time, and withdrawal prior to the maturity date usually incurs an interest penalty. Examples of this type of account include certificates of deposit and savings certificates. The countable portion is the net amount available after application of any interest penalty.

- Safe Deposit Box

  Examine the contents of any safe deposit box the client owns individually or jointly to determine if the contents include any countable assets and total countable resources are within $100 of the appropriate resource limit. The examination may be conducted by a Department representative or a bank official. Prepare an itemized list of the contents for the case record.

- Uniform Gifts to Minors (UGMA)

  Under UGMA, an individual (donor) gives money or other assets irrevocably to a minor (donee). The gift is placed under the control of a custodian until the donee reaches the age of majority as established for the state (18 in Tennessee). The assets cannot legally be used for the custodian's benefits and are not considered resources or income for the custodian. The UGMA property including any additions or earnings is not income to the minor unless disbursements are made by the custodian to the minor. The UGMA property is income to the child the month age 18 (majority) is reached.

Any disbursements from UGMA to or for the benefit of the child are considered income in the month of receipt. If the donor is or becomes an institutionalized individual and applies for TennCare Medicaid, the UGMA donation is evaluated under transfer of assets provisions.

Verify the UGMA gift by viewing a copy of the document of ownership such as a deed, savings passbook, certificate of deposit or other written document by the donor designating the gift under UGMA. If there is no document designating an UGMA gift, the above exclusions do not apply.

Establishing Value and Ownership of a Bank Account

Accept written verification of ownership and the balance in a bank account including one of the following when the total countable resources are within $100 of the appropriate resource limit.

- Bank statement for the period in question.
- Written verification from the bank.

Record the following in the case record if using a bank statement for verification:

- Bank balance as of the first day of the month under consideration.
- Date of the bank statement.
- Bank account number.

If using any other type of verification, record the statement exactly in the case record.

Trust Funds

A trust is composed of the initial amount used to create the trust (the principal) and any income (usually interest) it may produce. The trustee holds legal title to the trust and manages it for the benefit or use of the beneficiary. Determine exclusion/availability of all trust assets for which a budget group member is either a trustee or a beneficiary.

For revocable trusts, the full amount of the trust principal is a countable asset. Interest which accrues to the account is considered unearned income. Withdrawals from the trust are not considered income but a resource conversion.

The policy outlined in this section regarding trusts applies to non-institutionalized individuals as well as institutionalized individuals except with regard to transfer of assets. The transfer of assets provisions apply only to the institutionalized individuals.

The following terms are used in the discussion of Trust Funds:

- **Trust** - Is a right of funds (property) held by an individual (trustee) for the benefit of another beneficiary or by an individual for self-benefit.

- **Legal Instrument Or Device Similar To A Trust** - Any instrument that resembles a trust which includes but is not limited to escrow accounts, pension funds, annuities, and other similar entities managed by an individual or entity with fiduciary responsibilities.

- **Grantor Trust** - The grantor of the trust is the sole beneficiary of the trust (i.e., the grantor establishes a trust for him/herself).

- **Mandatory Trust** - Requires the trustee to pay to or for the beneficiary's benefit, the trust's earnings and/or principle at certain times in specified amounts or for a specified type of care. The trustee has no discretion on distribution from the trust.

- **Discretionary Trust** - The trustee has discretion to use trust for beneficiary's needs as he/she deems appropriate. The beneficiary has no control over the trust.

- **Trustee** - The person who holds the legal title to funds for the benefit or use of another.

- **Beneficiary** - The person for whose benefit the trust is created.

- **Grantor/Trustor** - The person who creates a trust Effective 8-11-93, the person includes a court or administrative body with legal authority to act in place of or on behalf of or at the request or direction of the individual or his/her spouse.

- **Totten Trust** - A tentative trust in which the grantor makes him/herself trustee of his/her own funds for the benefit of another. The trustee (grantor) can revoke the trust at any time. If the trustee dies before revoking the trust, the beneficiary becomes owner of the trust. The terms of the trust will indicate how the trust is to be used or what limits are placed for the use of the funds by the trustee.

Medicaid Qualifying Trust (Established prior to 8-11-93)

Policy

These provisions apply only to trusts established prior to 8-11-93 when assistance is requested on or after 6-1-86. A Medicaid Qualifying Trust is a trust or similar legal device established by an individual, his/her guardian or his/her spouse for the benefit of the individual, other than by Will. The individual may be the beneficiary of all or part of the payments of the trust as determined by the trustee. This type of trust is a countable resource whether or not it is designated as revocable or irrevocable or was established for purposes other than to enable the client to qualify for TennCare Medicaid. The amount available to the client is the maximum amount of payments permitted under the terms of the trust by the trustee. When the language of the trust is unclear or nonspecific regarding the amount of funds that may be distributed by

the trustee, obtain an interpretation from the attorney assigned to the DHS District in which the DHS office is located.

Hardship Provisions

The funds in a Medicaid Qualifying Trust will not be considered a resource if this would result in undue hardship to the client. For purposes of this policy, undue hardship will exist only when:

- The funds in the trust have been, or are being used on necessities such as clothing, food and shelter, the loss of which was caused by a natural or casualty disaster, and such losses are not covered by any third party coverage.
- The funds in the trust have been or are being used on funeral or burial expenses of an immediate family member.
- The funds in the trust have been or are being used to prevent or rectify a situation which endangers the health and well-being of the client or his/her immediate family.

NOTE: If a beneficiary of a trust is a mentally retarded individual who resides in an intermediate care facility for the mentally retarded (ICF-MR), that individual's trust is not considered a Medicaid Qualifying Trust provided the trust was established prior to 4-7-86, and is solely for the benefit of the mentally retarded individual.

Irrevocable Trusts

An irrevocable trust is a trust or similar device which the grantor cannot revoke or modify in any way or under any circumstances.

Trust Created by a Will

A trust created by a will is never considered a Medicaid Qualifying Trust. Determining the countable value of the trust as a resource to the beneficiary depends upon the terms of the will. The terms of the will may specify that only the income or both the income and the principal are available to the beneficiary. In addition, the terms may specify that the beneficiary has limited access to the funds or that only the trustee or the court has access to the trust amount. If the trustee has the discretion to use the trust principal for the client's support and maintenance and/or medical needs, the value of the trust is an unavailable asset as described above, but the trust itself is a third party medical resource and as such is reported to the Bureau of TennCare. Send a copy of the trust document and a brief written summary of the circumstances to the Third Party Liability Unit, Bureau of TennCare.

Irrevocable Trust (Established Prior to 8-11-93)

This policy applies to trusts that are not considered Medicaid Qualifying Trusts and that were not established by a will. If the trust is legally irrevocable and the beneficiary is not a FRR or one for whom the client is financially responsible, the individual does not have access to the

Irrevocable Trust and Similar Devices/Legal Instruments (Established 8-11-93 and later)

An irrevocable trust or similar device which contains an individual's own assets that forms all of or part of the principal of a trust and is established, (other than by will) by the individual; his/her spouse; or by a person (including a court or administrative body) with legal authority to act on behalf of or at the direction or request of the individual or his/her spouse is subject to the policy outlined below. For institutionalized individuals, the look back period for trust transfers of assets is 60 months if no disbursement can be made to or for benefit of the individual or 36 months if disbursement can be made to or for benefit of the individual. The following policy applies to that portion of the trust which includes the assets of the individual regardless of the purpose for the trust; or whether the trustees have or exercise any discretion under the trust; or any restrictions on distributions or use of distributions:

- Any payments from the trust paid to or for the benefit of the individual for any purpose are considered income to the individual unless payment is made for medical are or other purposes in which it is not considered income under SSI policy;

- Income on the corpus (principal) of the trust or any portion of corpus which could be paid to or for the benefit of the individual is considered an available resource to the individual;

- Any other payments from the trust for any other purpose will be considered a transfer of assets for institutionalized individuals subject to the transfer of assets penalty.

If any portion of the trust containing the individual's assets cannot be considered as income or a resource, it is considered a transfer of assets for institutionalized individuals from the date the trust is established, or payment to the individual is foreclosed, and the look back period is 60 months. The corpus of the trust is the value of the transferred asset. Any additions to the irrevocable trust in which no disbursements can be made will be considered a transfer of assets at the point the addition is made.

Trust Produces Income (other than Medicaid Qualifying Trust)

If the trust was established by the terms of a will and/or is producing regular income for the beneficiary and the terms of the trust specify:

- that the beneficiary does not have access to the trust principal and/or income and

- that such access is limited to the trustee or to the court, and

- the trust does not contain the beneficiary's own assets, thenthe value of the trust is not a countable asset. Any payments the client receives from the trust are considered unearned income. If the client does not have access to the principal but receives regular payments from the interest income, exclude the value of the trust as an unavailable asset and count the interest payments as income. If the trustee has the discretion to use the trust principal for the client's support and maintenance and/or medical needs, the value of the trust is an unavailable asset as described above, but the trust itself is a third party medical resource and as such is reported to the Bureau of TennCare. Send a copy of the trust document and a brief written summary of the circumstances to the Third Party Liability Unit, Bureau of TennCare.

Other Trusts (Excluding Medicaid Qualifying Trusts)

If the trust is not one created by a will, a Medicaid Qualifying Trust, or regularly producing income as previously described, then consider the value of the trust. If the trust was established by means other than a will and/or contains no income or assets of the beneficiary, temporarily exclude the value as an unavailable asset if the client agrees to take steps to have the principal made currently available.

If the beneficiary of the trust is a FRR or one for whom the client is financially responsible, the client must take steps to have the resource made currently available unless the trust was established by a will or is producing income to the beneficiary. The caretaker of a child for whom a trust of $5000 or less has been established is not required to petition the court to make the trust available. In most instances, the legal fees involved in such an attempt would erode the value of the trust to the extent that it would not be cost effective to bring it to the state of availability. However, if the trust is over $5000, allow the individual or his FRR 60 days from the date of application or redeterminaton to seek to have funds made currently available. Exclude the value of the trust as an unavailable asset during the 60-day period. At the expiration of the 60 day period, secure verification that the client fulfilled the terms of the agreement. If he took action, set up an Expected Change and follow up on the status of the client's request for current availability at least every 60 days or more frequently if deemed appropriate. Continue to exclude the value of the trust as an unavailable asset.

If the client or his FRR has not taken steps necessary to have the trust funds made currently available, and he is a FRR of budget group members, remove the caretaker from the BG but continue to count his/her income in determining income eligibility for the group. If the caretaker is included in the aid group, terminate his/her coverage. During the initial and subsequent 60 day exclusion period(s), if the trustee has the discretion to use the trust principal for the client's support and maintenance and/or medical needs, the value of the trust itself is an unavailable asset, but the trust itself is a third party medical resource and is reported to the Bureau of TennCare.

SSI-Related Treatment of Trusts

Under SSI policy for trusts in which the principal is not an available resource, any disbursements are considered as income. Disbursements made to a third party for items that

are not food, clothing, or shelter are not income. The principal is an available resource, any disbursements are considered a conversion of a resource. The trust principal is considered a resource. Any earnings are counted as income when paid to the individual.

Exceptions to Policy for Trusts Established 8-11-93 and Later

Treatment of trusts as transfers of assets does not apply in the situations below; however, funds entering and leaving the types of trust listed here are treated according to SSI-related policy as explained in that section below.

Trusts for Disabled Under Age 65

A trust containing the assets of an individual under age 65 who is disabled (by SSI definition of disability) which was created solely for the benefit of that individual by a parent, grandparent or legal guardian or a court is not treated as a transfer of assets, IF the state will receive certain amounts remaining in the trust upon the individual's death. The amount payable to the state is the total medical assistance paid on his/her behalf by Medicaid and/or TennCare. NOTE: The trust does not lose its exemption for transfer of assets when the disabled individual becomes age 65 unless funds are added after age 65. The added funds would be considered a transfer of assets.

Special Needs (Pooled) Trusts

A trust containing the assets of a disabled individual (i.e., SSI definition of disabled) which meets the following conditions will not be considered a transfer of assets:

- The trust is established and managed by a non-profit association and a separate account is maintained for each trust beneficiary, but trust accounts are pooled for investment purposes and management of funds; AND

- The account in the trust is established solely for the benefit of the disabled individual by a parent, grandparent, legal guardian, the individual or by a court; AND

- Any remaining amounts in trust not retained by the trust, upon the beneficiary's death, are to be paid to the state in amount equal to the total medical assistance paid on the beneficiary's behalf by the state.

Qualified Income Trust (Miller Trust) Effective July 1, 2005

The State of Tennessee received clarification from the Center for Medicare and Medicaid Services (CMS) on September 8, 2005, of the requirement for Tennessee to implement Qualified Income Trust (QIT) policy for those individuals admitted to or soon to be admitted to long-term-care facility, ICF-MR or Home and Community Based Services. Effective July 1, 2005, when a state no longer has the Medically Needy category as an option for institutionalized adults, the state may allow an individual's monthly income to be placed in a QIT when their gross income is over the Medicaid Income Cap (300% of the SSI Federal

Benefit Rate or FBR). This may enable an individual to qualify financially for Medicaid coverage as categorically eligible. Detailed policy guidelines are included below.

Qualified Income Trust (Miller Trust)

QIT Defined

A QIT is a trust consisting only of the individual's pension income, Social Security income and other monthly income that is created for the purpose of establishing income eligibility for Medicaid in order to receive Medicaid coverage when an individual is or soon will be confined to a nursing facility or Home and Community Based Services (HCBS) Waiver program (collectively, Long Term Care Setting or LTC setting).

QIT Policy

For the purpose of determining Medicaid eligibility of an applicant/recipient who is or soon will be confined to a LTC setting, either in a nursing home or a HCBS waiver, and whose income is over the Medicaid Income Cap (MIC); such individual may still qualify for Medicaid coverage if some or all of his or her income is placed in a valid Qualified Income Trust (Miller Trust). Such individual must also meet all other Medicaid eligibility requirements, such as resource limit, 30 days continuous confinement requirement in a nursing facility or for individuals applying to enroll in HCBS, the individual is determined to need and to be likely to receive services for a continuous period of at least 30 days going forward, and may have an approved Pre-Admission Evaluation by the Bureau of TennCare.

Income placed in a valid QIT will be treated as unavailable in accordance with federal standards. For the Trust to be valid, the individual's gross monthly income must be above 300% of the Supplemental Security Income Federal Benefit Rate (SSI FBR), which is $1911, effective January 1, 2008. Any income that is not placed in the QIT must be below the Medicaid Income Cap (MIC) of $1911. If income not placed in the QIT is over the MIC, the individual is not eligible financially regardless of the income placed in the QIT. An individual whose income is placed in a QIT and who is subsequently found to be eligible for Medicaid will be considered eligible on the first day of the month in which eligibility is established, or the date of admission to the nursing home or HCBS program, whichever is later.

Income Test

The amount of income applicant/recipient places in a QIT cannot be limited nor can it e counted when testing income against the MIC of $1911 (effective January 1, 2008). However, it is used in determining patient liability during post eligibility. Income that is not placed in the QIT is tested against the MIC. If the applicant/recipient income that is not placed in a QIT is over the MIC, the individual is not income eligible for nursing home Medicaid.

Criteria for a Valid Trust

- The Trust must be irrevocable and cannot be modified or amended in whole or in part by the Grantor at any time. However, the Trustee or a court of competent jurisdiction shall have the right and jurisdiction to modify any provision of the Trust to the extent necessary to maintain the eligibility of the Grantor for medical assistance.

- Each month the Trustee shall distribute the entire amount of income transferred into the Trust except for an amount not to exceed $20 for expenses of the Trust.

- The sole beneficiaries of the Trust are the individual for whose benefit the Trust is established and the State of Tennessee (Bureau of TennCare). The Trust terminates upon the death of the individual, or the Trust is no longer required to establish Medicaid eligibility in the State of Tennessee, if nursing facility care or HCBS is no longer medically necessary for the individual, or if the individual is no longer receiving such services.

- The Trust must provide that upon the death of the individual or termination of the Trust, whichever occurs sooner, the State of Tennessee (Bureau of TennCare) shall receive all amounts remaining in the Trust up to the total amount of medical assistance paid by the State on behalf of the individual.

- Amounts remaining in the Trust that are owed to the State must be paid to the Bureau of TennCare within three months after the death of the individual or termination of the Trust, whichever is sooner, along with an accounting of the disbursements from the Trust. The Bureau of TennCare may grant an extension if a written request is submitted within two months of the termination of the Trust.

- The regulation in this section for Trusts shall apply to an income trust established on or after July 1, 2005, and with the under hardship provision in Section 1613 (e) of the Social Security Act, which is currently outlined in this manual (chapter 15, pg. 22.4C5) Hardship may be considered to exist when the institutionalized spouse and/or his/her spouse would have resources in excess of the resource limit, is otherwise eligible, and for whom Medicaid ineligibility would result in loss of essential nursing care which is not available.

Allowable Monthly Disbursements

Other than payments under section D1, the allowable disbursements from the Trust are limited to:

- Personal Needs Allowance (PNA) – the amount the individual is allowed to retain for his/her personal needs under Tennessee's Medicaid policies. As of January 1, 2005, this amount is $40.

- A deduction of up to $20 for expenses necessary for managing the trust (i.e. bank charges).
- Spousal/Dependent Allocation as policy allows.
- Health Insurance Premiums – allowed when the individual has health insurance other than Medicaid (for example, Medicare premium or a Medicare supplement policy).
- Item D - payment for types of medical or remedial care recognized under state law, but not covered as medical assistance under the State's Medicaid program. (Qualifying medical or remedial care is specified in DHS Medicaid State rules).

Payment for Nursing Facility Care, HCBS, and other Medicaid Covered Services

Any countable income not placed in the QIT and any Trust income remaining after allowable deductions are made shall be paid monthly to the facility by the individual or from the Trust in an amount not to exceed the Medicaid reimbursement rate. Any excess income not distributed from the Trust shall accumulate in the Trust monthly.

Restrictions on Other Expenses

No other deductions or expenses may be paid from the Trust. Expenses which cannot be paid from the Trust, except as specifically provided herein include, but are not limited to, trustee fees, attorney fees and costs (including attorney fees and costs incurred in establishing the trust), accountant fees, court fees and costs, fees for guardians ad litem, funeral expenses, past due medical bills and other debts.

Home and Community Based Services (HCBS)

For an individual with a valid Trust receiving HCBS, the following methodology will be used to determine the financial liability of the individual for the cost of care.

Determine the amount of the individual's gross monthly income. Based on federal regulations and guidance, all of the individual's income is counted, including the amount placed in the Trust. Deduct the individual's Personal Needs Allowance (PNA). The PNA for HCBS is an amount equal to 200% of the SSI FBR ($1274 in 2008). A deduction up to $20 for trust expenses i.e. bank charges is allowed. A deduction may be made for spousal allocation, health insurance or any approved non-covered medical or remedial care expense (Item D). Approved non-covered services are listed in DHS State Rules. The remainder, after the above deductions, is the individual's financial liability amount.

Example #1

Sandra Fielding applied for Medicaid on 6/1/05 for her father, Thomas Fielding. He receives a monthly pension from Wells Fargo of $1263 and Social Security of $1911. Her father's income exceeds the Medicaid Cap so she establishes an Income Trust on 6/12/05 to qualify. She places her father's Social Security income of $1911 in the QIT. He has no other source of income or

health insurance premiums. Because of the QIT, he is now categorically needy. Mr. Fielding's budget is calculated as follows:

		NF	HCBS	
Qualified Income Trust		1911.00	1911.00	
Private Pension	+	1263.00	1263.00	
Countable Gross	=	3174.00	3174.00	Because the non QIT income is under the MIC continue to work the patient liability budget.
Personal Needs Allowance	-	40.00	1274.00	
	=	3134.00	1900.00	
Trust Fee	-	20.00	20.00	
Patient Liability	=	3114.00	1880.00	
Other qualifying deductions		0.00	0.00	
Patient liability		3114.00	1880.00	

- Because $1911 was placed in a Qualified Income Trust, it is considered unavailable. The $1263 pension check is counted as income and must be compared to the Medicaid Cap to determine income eligibility.

- The income trust, along with any other income, is counted in determining how much the individual will pay toward the cost of nursing home care.

- In this example, you would deduct the personal needs allowance and trust fees (not to exceed $20).

- Application approved for 7/1/05 (the date QIT policy became effective).

Example #2

Susan Jones applies on 7/20/05 for her mother, Joyce Singleton, who was just admitted to a nursing home. Her mother's Social Security income of $3000 exceeds the Medicaid Cap so she places all her funds in a QIT to qualify. Ms. Jones places all her mother's income in the account beginning 8/8/05. Ms. Singleton has no other source of income. She pays a monthly health insurance premium of $100. Because of the QIT, she is now categorically needy.

Ms. Singleton's budget is calculated as follows:

		NF	HCBS
Qualified Income Trust		3000.00	3000.00
Other income	+		
Countable Gross	=	3000.00	3000.00
Personal Needs Allowance	-	40.00	1274.00
	=	2960.00	1726.00
Trust Fee	-	20.00	20.00

Patient Liability	=	2940.00	1706.00
Health Insurance Premium	-	100.00	100.00
Patient liability	=	2840.00	1606.00

There is no income test against the MIC, so continue to the patient liability budget.

- Ms. Singleton's income of $3000 is over the Medicaid Cap of $1869. Her daughter placed all funds in a Qualified Income Trust (QIT). This makes the income unavailable for Medicaid purposes.
- In this example, you would deduct the personal needs allowance, trust fee (up to $20), and health insurance premiums.

Example #3

Tom Jones receives $1800 per month from VA Compensation. He places $100 of his VA Compensation in a Qualified Income Trust every month.

		NF	HCBS
Qualified Income Trust		100.00	100.00
VA Compensation	+	1700.00	1700.00
Countable Gross	=	1800.00	1800.00
Personal Needs Allowance	-	40.00	1274.00
	=	1760.00	526.00
Trust Fee	-	20.00	20.00
Patient Liability	=	1740.00	506.00

- The income trust, along with any other income, is counted in determining how much the individual will pay toward the cost of nursing home care.
- Application approved for 7/01/05, because eligibility may begin the first day of the month in which the needed amount of Mr. Jones' income was placed in the QIT.

Example #4

Individuals enrolled in the MR Self-Determination waiver have a personal Needs Allowance in the amount of 300% of the SSI/FBR ($1911 2008).

John Block enrolled in the MR waiver on November 1, 2007. He has an approved PAE and applied for Medicaid on the same date. Mr. Block receives $3,000 monthly from a trust that was created by a will. Because Mr. Block's income is over 300% of the SSI/FBR, he placed all his income in a Qualified Income Trust.

		ICF/MR
Qualified Income Trust		3000.00
Personal Needs Allowance	+	1911.00
		1089.00
	-	20.00
	=	1069.00

Example #5

Mr. Theodore Smith applied for Nursing Home Medicaid on June 30, 2005. Mr. Smith receives $2000.00 per month in SSA and $2000.00 per month in a retirement pension. He placed all of his income a QIT. The per diem rate for the nursing home is $98 per day; when converted to a monthly average cost of care is $2940.00.

Quality Income Trust		4000.00	4000.00
Other income	+	0.00	0.00
Personal Needs	-	40.00	1274.00
Allowance		3960.00	2726.00
Trust Free	-	20.00	20.00
Patient liability		3940.00	2706.00

ACCENT's Budget would reflect what is displayed above, but the facility can only bill for the actual cost of care based on a daily rate ($98). The remainder of the income placed in the QIT would remain in the QIT. Income that remains in the QIT would be disbursed once the trust is no longer needed.

Because there is not a limit to the amount of income an individual may place in their QIT and remain categorically eligible, if Mr. Smith is otherwise eligible, his case may be approved with an effective date of July 1, 2005.

Please document in running comments on ACCENT the amount of income that the applicant/recipient placed in the QIT in the month eligibility was established and the name of the trustee and his/her address. The amount of income in the QIT can be found on Schedule A of the trust document. Since an individual's income may change, please inform the applicant/responsible party that changes must be reported within 10 days.

NOTE: When a case is approved based on QIT policy:

1. Information is to be submitted to a new Groupwise e-mail address:

   DHS, QIT.Miller Trust - QITMillerTrust.DHS@State.tn.us

2. Copies of the Miller Trust/QIT documents are to be mailed or faxed to:

   Bureau of TennCare
   Attention: Miller Trust/QIT Contact
   310 Great Circle Road
   Nashville, TN 37243
   Fax #615-532-7509

Hardship Conditions Exist

A penalty will not apply if it is determined that the funds in the trust have been, or are being used on necessities such as clothing, food and shelter, the loss of which was caused by a natural or casualty disaster, and such losses are not covered by any third party coverage. The funds in the trust have been or are being used on funeral or burial expenses of an immediate family member, or the funds in the trust have been or are being used to prevent or rectify a situation which endangers the health and well-being of the client or his/her immediate family.

Revocable Trusts

A revocable trust is a trust or similar legal device which can be revoked by the grantor or proof is provided that it can only be modified or terminated by a court. An irrevocable trust which terminates if some action is taken by the grantor is considered a revocable trust. For example, a trust requires termination if a beneficiary leaves the nursing home.

Revocable Trusts (Established Prior to 8-11-93)

For revocable trusts established prior to 8-11-93, the full amount of the trust is a countable asset. Interest which accrues to the account is counted as unearned income. Withdrawals from the trust are not considered income, as they are conversion of a resource.

Revocable Trusts (Established 8-11-03 and later)

Any revocable trust or similar device established 8-11-93 and later which contains an individual's assets that form part or all of the revocable trust, was established by the individual, his/her spouse, or a person (including a court or administrative body) with legal authority to act in behalf or at the direction or request of the individual, or his/her spouse is subject to the policy outlined below:

- The principal of the trust is considered an available resource for all TennCare Medicaid categories (institutionalized or non-institutionalized);

- Any payments from the trust to or for the benefit of the individual are considered income of the individual in all TennCare Medicaid categories; and

- Any other payments made for any other purpose are considered a transfer of assets if within the past 60 days of application as an institutionalized individual.

The exceptions cited above for irrevocable trusts apply for revocable trusts; however, the funds in a revocable trust are available, and therefore countable as a resource.

Annuities

The term "trust" includes annuities. Annuities are generally periodic payments generated by a bank or insurance company from funds deposited by an individual either in a lump sum or by periodic installments to establish a source of income for a future period. In some cases, however, the annuity may have been established to shelter assets; therefore, a determination must be made as to whether the individual will receive fair market value for his deposited funds.

To determine fair market value, use the life expectancy tables to determine the individual's life expectancy (i.e., average number of years of expected life remaining based on current age and sex).

DRA 2005 also added a provision for the treatment of the purchase of certain annuities as a transfer for less than fair market value.

When an application or re application is filed for long-term care services, a statement that names the State as remainder beneficiary on any annuity must be disclosed. The issuer of an annuity may disclose information about the State's position as remainder beneficiary to others who have remainder interest in the annuity.

Consideration of Income and Resources from an Annuity

The income or resources derived from an annuity may be considered during the determination for Medicaid eligibility. This means even though an annuity is not penalized as transfer for less than fair market value, it must still be considered in determining eligibility, including spousal income and resources, and in post-eligibility calculation, as appropriate. In other words, even if an annuity is not subject to penalty under the provisions of the DRA, this does not mean that it is excluded as income resources.

Evaluation and Treatment of Purchase of Annuities and Certain Transactions Related to Annuities On or After February 8, 2006.

For annuities purchased prior to February, 2006, routine changes do not require any action on after the effective date of enactment and are not considered transactions that would subject the annuity to treatment under the provisions of the DRA. Routine changes are an address change, death or divorce of the remainder beneficiary and similar changes. Changes which occur based on the terms of the annuity which existed prior to February 8, 2006, and did not require any action to take effect are not subject to the provisions of the DRA.

EXAMPLE: An annuity was purchased in June 2001 included terms which require distribution to begin five years from the date of purchase, and payouts began as scheduled on June 2006. This will not be considered a transaction subject to the DRA, since no action was required, before enactment, to begin the change. (Changes which are beyond the control of the individual, such as a change in the

law, a change in the policies of the issuer, or a change in terms based on other factor, such as the issuer's economic conditions, are not considered transactions that cause the annuity to be subject to terms of the DRA.)

However, DRA does apply to transactions, including purchases, which occur on of after February 8, 2006. These actions include additions of principal, elective withdrawals, request to change the distribution of the annuity, election to annuitize the contract and similar actions taken by the individual on or after February 8, 2006. Such transactions result in all provision of the DRA being applicable to the annuity.

The above provisions of the DRA as it relates to annuities apply to the individual for whom long term care services are requested, but do not apply to annuities for which the community spouse, minor or disabled adult child is the annuitant.

The burden of proof that his/her annuity meets all the criteria is on the applicant/recipient. If verification is not provided, consider the annuity a transfer of assets.

Note: If the State is not named as a remainder beneficiary in the correct position, the purchase of the annuity will be considered a transfer for less than fair market value. This means that the full purchase value of the annuity will be considered the amount transferred.

States must notify applicants and recipients of the State's rights regarding annuities purchased on or after February 8, 2006.

Requirement to Name the State as a Remainder Beneficiary on Annuities

The purchase of an annuity shall be treated as a disposal of an asset for less than fair market value unless the State is named as a remainder beneficiary. For annuities purchased by an applicant or by a spouse, or transaction made by the applicant or spouse on behalf on behalf of the applicant, the State must be named in the first position for the total amount of medical assistance paid on behalf of the annuitant, unless there is a community spouse and/or a minor or disabled child. A child is considered disabled if he or she meets definition of disability found in section 1615(a) (3) of the Social Security Act. If there is a community spouse and minor or disabled child and any of those individuals dispose of any of the remainder annuity for less than fair market value, the State may then be named in the first position.

As a remainder beneficiary, the State may receive up to the total amount of medical assistance paid on behalf of the individual, including both long-term care serves and Home and Community Based Services. The State must notify the issuer of the State's right as the preferred remainder beneficiary and the issuer must notify the State if there are any changes in the amount of income or principal being withdrawn.

Annuities Purchase by or on Behalf of an Annuitant Who Applied for Medical Assistance.

An annuity purchase by or on behalf or an annuitant who has applied for medical assistance will not be treated as a transfer of assets if the annuity meets any of the following conditions:

- The Annuity is considered either an individual retirement annuity (according to Sec. 408(b) of the Internal Revenue Code of 1986 (IRC); or a deemed Individual Retirement Account (IRA) under a qualified employer plan (according to Sec. 408 (q) of the IRC).

- The annuity is purchased with proceeds from one of the following:

  - A traditional IRC (IRC Sec. 408a); or
  - Certain accounts or trusts which are treated as traditional IRA's (IRC Sec. 408 § (c); or
  - A simplified retirement account (IRC. 408 § (p); or
  - A simplified employee pension (IRC Sec. 408 § (k); or
  - A Roth IRA (IRC Sec. 408A)

OR

- The annuity meets all of the following requirements:

  - The annuity is irrevocable and non assignable; and
  - The annuity is actuarially sound; and
  - The annuity provides payments in approximately equal amounts, with no deferred or balloon payments.

NOTE: Even if an annuity is determined to meet the requirements above, and the purchase is not treated as a transfer, if the annuity or the income stream is transferred, except to a spouse or disabled or minor child that transfer may be subject to a penalty.

NOTE: All applicants who apply for long-term care Medicaid must disclose if they have an interest in an annuity on or after February 8, 2006. The active recipient may be given an additional 60 days to modify the annuity in order to comply with the criteria mandated by the DRA.

Prepaid Burial Agreements

Prepaid Burial Agreement Defined

Prepaid burial agreements are a form of trust fund created by entering into a contract with an organization (usually a funeral home) that is in the business of making funeral arrangements.

For Family and Children's Categories of TennCare Medicaid, exclude burial agreements of the client and for each household member. This includes burial agreements that are revocable or irrevocable.

For other TennCare Medicaid categories, the burial principal and interest are available to the individual to the extent that the agreement into which he entered is revocable.

Revocable Prepaid Burial Agreements

- Countable Value

  The value of a revocable prepaid burial agreement or trust owned by the individual is a countable asset.

- Establishing Ownership

  The owner of the trust is the individual in whose name the trust was created. This must be verified by a copy of the trust agreement, by confirming ownership with the funeral home, or by the bank where the funds are held.

  The current value for the trust is composed of initial principal deposited, any additional deposits and incurred interest less any processing fees charged to the client for dismantling or encroaching upon the trust.

Irrevocable Burial Agreements

- Countable Value

  For Irrevocable burial agreements established prior to 7-1-95, the funds in an irrevocable burial agreement or trust are not available to the owner and are excluded in their entirety as unavailable assets under the conditions listed below. The value of any "pre-need" burial agreement executed before 7-1-81 that has not been declared irrevocable by a court is a countable asset.

  For Irrevocable burial agreements established 7-1-95 or later, any funds in an irrevocable burial agreement in excess of the $6000 for institutionalized individuals are considered under the transfer of assets provision unless additional expense are incurred for transporting the deceased to another city or state for funeral/burial purposes. For example: an irrevocable burial agreement of $8000 was purchased 7-15-95. There is no additional expense in excess of the $6000 anticipated for transporting the deceased. Consequently, $2000 and any interest on that amount would be considered a transfer of assets for institutionalized individuals.

- Excluded Value of Irrevocable Burial Agreements

  For burial agreements established prior to 7-1-95, exclude the entire value of any irrevocable prepaid burial agreement or trust that meets the following criteria:

  - Any "pre-need" burial agreement purchased 7-1-81 or later is excluded as a countable resource if the contract contains the following statement: "This contract is irrevocable and the funds paid hereunder are not refundable."

  - Any "pre-need" burial agreement purchased before 7-1-81 may be excluded as a countable resource if a chancery, circuit, probate, or general sessions court declared it to be irrevocable. Secure verification of the court's action before excluding the funds in this type of trust.

    For burial agreements established 7-1-95 and later

  - Irrevocable established by client

    All funds including interest payments of a "reasonable" burial agreement are excluded if the value of the agreement does not exceed $6000 for each individual for all adult TennCare Medicaid categories. Interest payments and cost of transport which cause the agreement value to exceed $6000 are excluded also.

  - Irrevocable established by funeral home/director

    Irrevocable trusts/agreements established by the funeral home or director are not subject to the $6000 limitation at this time even if established by request of the client through payment of cash or assignment of life insurance and/or annuity to the funeral home/director. An itemized list of merchandise and costs is required for all TennCare Medicaid categories; however, a transfer of assets determination must be made for institutionalized individuals.

The owner of the burial agreement or trust is the individual who deposited the funds to create the trust, usually the beneficiary. Verify ownership by securing a copy of the burial agreement. The current value of the trust is the sum of the amount of the initial deposits, any subsequent deposits and accrued interest. Verify the amount by reviewing the trust agreement, written verification from the funeral home or from the bank holding the funds.

Life Insurance

For Family and Children's TennCare Medicaid categories, exclude the value of all life insurance policies owned by clients for each household member. This includes any cash value they may have accumulated. This exclusion applies to the family and children's categories only.

In determining resource eligibility for all other TennCare Medicaid categories, life insurance is considered an asset to the extent of its cash surrender value. The following terms are used in discussing life insurance:

- **Insured** – the individual upon whose life insurance is affected.

- **Beneficiary** – the individual, entity, or organization named in the insurance contract to receive the policy's proceeds upon the death of the insured.

- **Owner** – the individual who has the right to change the policy and is normally the person who pays the premiums.

- **Face Value** – the basic death benefit or maturity amount of a policy specified on its face, excluding dividends or any additional amounts payable to accidental death or other provisions.

- **Cash Surrender Value** – the amount, which increases with the age of the policy, the insurer will pay (usually to the owner) upon cancellation or surrender of the policy before the death of the insured or maturity date of the policy.

- **Dividends** – any interest paid by the insurance company to its policy holders is referred to as dividends. If dividends are paid, they may be paid directly to the owner, added to the cash value of a policy, or to purchase additional coverage, i.e., increase the face value.

- **Insurer** – the company or association which contracts with the owner of the insurance to provide insurance coverage.

Types of Life Insurance

There are two major groups of life insurance: those that may accrue a cash surrender value, and those that do not accrue cash surrender value (CSV). Within these groups, there are several types of insurance. In determining countable/excluded values of an individual's life insurance, count only the face value(s) of the types of policies that accrue a CSV.

- Insurance with Cash Surrender Value

  An ordinary, whole or straight life policy is a contract for which the insured pays premiums during his lifetime or up to age 100 and the company pays the face value of the policy to the beneficiary upon the death of the insured.

  A limited payment policy is a contract for which the insured makes payments for a specific number of years rather than for his whole life and the company pays the FV of the policy to the beneficiary upon the death of the insured.

An endowment policy is a contract that promises payment of the FV of the policy either upon the death of the insured or within a specific period of time.

- Insurance with No Cash Surrender Value

  Term life insurance is a type of contract for which the insured receives temporary protection (for a specific period of time) or limited protection through a steadily decreasing face value.

  Sick and accident insurance primarily provides income to the insured if he becomes disabled, but it may include a death benefit for accidental death.

  Burial insurance is insurance whose terms specifically provide that the proceeds can be used only to pay the burial expenses of the insured.

Excluded Value

Exclude the cash surrender value of all life insurance policies the individual owns if the total face value of those policies does not exceed $1500.00. During a month when deeming applies, exclude the CSV of life insurance policies owned by each of the individual's FRR(s) if the total face value of all the policies the relative owns is $1500 or less.

Count only the CSV of policies available to the client. The CSV may be unavailable to the client for one of the following reasons:

- If the consent of the co-owner(s) is required to surrender a policy for its CSV, and the consent cannot be secured and the co-owner(s) is other than a FRR, the CSV of that policy is an unavailable resource.

- IF the policy has been assigned to another individual, his consent for surrender is required. If he declines to give his consent, exclude the CSV as an unavailable asset. If the assignment took place within 30 months of the client's application for benefits or the redetermination of his eligibility, examine the assignment in light of the transfer of assets provision.

Countable Value

The total net cash surrender value of life insurance policies owned by the individual is a countable resource if the total face value of those policies is greater than $1500. The net value is equal to the total CSV less the amount of any outstanding loans made against it. Count only the CSV available to the individual.

Establishing Ownership

The owner of an insurance policy is the person who has the right to change the policy. Normally, this is the same individual who pays the premiums. Usually, the owner of a life

insurance policy is also the insured and ownership can be verified by seeing the policy or by written correspondence with the insurance company or the client's insurance agent. If the client alleges ownership of policies for which he is not the insured, ownership may be verified by seeing the policy if the owner's name is included on its face or by written correspondence with the insurance company or the individual's insurance agent.

Establishing Value

Consult the table of cash values on the policy itself. These tables usually indicate CSV at one to five year intervals from the date the policy was issued. Use the CSV from the chart in determining the countable value of the life insurance unless the client can provide written verification from the insurance company of a lesser value. Document the case record with findings.

If the CSV table is not available or the life insurance policy is paid up, the only acceptable verification of value is secured in writing from the insurance company. In the interim, an alternate method of valuation, the Presumed Value Method, can be used under certain conditions. Use the Presumed Value Method to determine CSV unless it appears that dividends have been added to the basic cash surrender value of the policy or the client alleges the policy is encumbered. If these conditions apply, accept only written verification of the CSV. In all other cases, the Presumed Value Method is acceptable verification of value until written verification of the current CSV can be secured from the insurance company.

- Presumed Value Method

  Use the following method to determine the CSV of policies that are paid-up or which have no CSV tables available and which have no dividends added to the basic CSV:

  - Determine the number of years the policy has been in effect.
  - Consult the table entitled Presumed Valuation Table to obtain a percentage amount.
  - Multiply the percentage amount by the face value of the policy.
  - The result is the presumed CSV.

    NOTE: If the presumed value is used and later verification is received that the actual value is greater, there is NO error or overpayment.

PRESUMED VALUATION TABLE

Years in Effect	Percentage of Face Value
20 or more	60%
15 – 19	50%
11 --14	45%
6 –10	30%
4 – 5	20%
3	10%
2	6%
1	2%

- Actual Value

  Obtain written verification of the cash surrender value from the insurance company. Include the following in your request:

  - Full name of the policy owner
  - Policy number
  - Date the policy was issued
  - Face value
  - Authorization to release information signed by client or responsible party

    Specifically request the paid-up cash value, the status of the policy, the amount of any outstanding loans, and the current CSV.

- Encumbered or Lapsed Policies

  Secure written verification from the insurance company or the client's insurance agent as described above for any life insurance policies that are either encumbered, i.e., the owner has borrowed against the policy's CSV, or the policy lapsed when the owner stopped paying the premiums.

- Accelerated Life Insurance Payments

  A life insurance company, or a privately owned and operated business, may offer to pay the owner of a life insurance policy money that normally would go only to the named beneficiary of the policy after the insured's death. Some policyholders may elect to receive lump sum payments; others may receive monthly payments only. There are no restrictions on how the payments can be spent. Although accelerated payment plans

vary from company to company, all of the plans involve early payout of some or most of the proceeds of the policy to the insured. Examples:

A life insurance company may pay out a percentage of the death benefit directly to the insured. The insured individual, therefore, becomes the policy's beneficiary.

A private company may enter into an arrangement with the owner of a policy whereby the company becomes the policy's beneficiary. The company may assume responsibility for the payment of any premiums due. In return, the insured individual receives a payment equal to a percentage of the policy's death benefit.

Since accelerated payments can be used to meet food, clothing or shelter needs, the payments are income in the month received and a resource if retained into the following month and are not otherwise excludable. The receipt of an accelerated payment is not treated as a conversion of a resource. This is because the individual receives proceeds from the policy, not the policy's resource value (i.e., its CSV).

Accelerated payments are not "benefits" for purposes of the requirement to file for other benefits. Therefore, an individual is not required to apply for accelerated payments as a condition of obtaining or retaining eligibility.

Pre-Paid Institutional Care

This policy applies only to individuals who have entered Title XIX long-term care facilities.

Prepaid Institutional Care Defined

Prepayment for care deposited by the individual upon his admission to a long-term care facility is prepaid institutional care. The value of this deposit is a countable asset for the individual who is subsequently approved for TennCare Medicaid benefits if the deposit was paid from the individual's own funds.

Deposit Policy

A long term care facility (LTCF) may require a deposit or prepayment of the first month's care upon admission. Medicaid regulations provide for certain restrictions regarding these deposits based on the individual's TennCare Medicaid eligibility status:

Deposits for the currently eligible individual are limited to the amount of his liability for the cost of care. The facility may not require the full amount of a month's cost of care nor require any deposit as a condition of admission.

The facility may require a deposit of any amount not to exceed whatever the facility "normally requires of all admitted patients" from any individual ineligible for TennCare Medicaid benefits at admission, including applicants for TennCare Medicaid. If the individual is subsequently approved for TennCare Medicaid benefits, the facility must refund that portion of

the deposit that was not used to pay for the individual's care, i.e., that amount paid by the TennCare Medicaid program. A refund is made after the facility is notified of the individual's eligibility for TennCare Medicaid benefits.

The Refund as a Countable Asset

The individual who paid a deposit upon admission to a LTCF and who is subsequently approved for TennCare Medicaid benefits, is eligible for a refund of the deposit (in whole or in part) from the facility.

The amount of the anticipated refund is a countable asset during the first month for which the individual has requested TennCare Medicaid coverage, usually the first month of institutionalization if the deposit was paid from the individual's own funds. Refunds of deposits paid from the funds of someone other than the client and/or his FRR(s) are not part of the client's countable assets.

Use the following procedure to determine the amount of the deposit that is a countable asset:

- Determine the total amount of the deposit and from whose funds it was paid.

- Subtract the amount of the individual's patient liability effective the first month of his eligibility for vendor payment from the total deposit paid.

- The result is the amount of the anticipated refund and part of the individual's countable assets throughout the first month for which the client has requested TennCare Medicaid coverage.

Use the following procedure to determine the individual's resource eligibility when part of his countable assets is an anticipated deposit for prepaid institutional care.

- Add the amount of the anticipated refund from the deposit to the rest of the individual's countable assets beginning with the first month for which the individual requested TennCare Medicaid benefits.

- If the amount of the individual's assets including the anticipated refund exceeds the resource reserve limit throughout the month, he is ineligible due to excess resources effective the first month for which he requested coverage. Assume the entire amount of the anticipated refund will be retained by the facility to cover the cost of care for the first month for which the client requested TennCare Medicaid coverage and was found to be resource ineligible. Beginning the first day of the following month (i.e., the second month for which the individual requested coverage), the anticipated refund is no longer a countable asset, as it is assumed to have been used to meet the individual's cost of care during the previous month.

- If the total amount of the individual's countable assets is within the appropriate resource reserve limit, he is resource eligible. Do not verify or budget the refund as

income in the month the individual actually receives it, as it has already been counted as an available resource. Beginning the month following the month in which the individual actually receives the refund, the value of the refund is considered a countable resource if retained.

The value of the refund of a prepayment of institutional care belongs to the individual who paid the deposit. The facility can verify who paid the deposit upon the client's admission. Resolve any discrepancies by requesting the client or responsible party provide some verification of payment.

Verify the full value of the deposit with the admitting facility or other verification of payment provided by the applicant. Compute the value of the anticipated refund of the item. The resultant amount is the value of the prepaid institutional care and a countable asset for the purposes of determining resource eligibility. It is not necessary to verify the actual amount of the refund.

Patient Trust Accounts

The institutionalized individual confined to a LTCF may have a Patient Trust Account (usually an interest bearing checking account) maintained by the facility into which the individual's Personal Needs Allowance is deposited along with any other funds the individual has deposited there. The current value of the Patient Trust Account is a countable asset and must be verified with the facility at every application, reapplication, or redetermination. Document the contact with the facility and include the patient trust account number, date of contact, name of the individual furnishing the verification, and the value of the trust account.

Stocks, Bonds, and Mutual Shares

Stock

Shares of stock represent ownership in a corporation or business. For incorporation purposes, stock is assigned a "par value", but their value as an asset is based on the market value. The market value of a stock is a countable asset unless the client can substantiate a lower value. Accept the client's sworn statement of ownership and/or see the stock certificate(s) if available. Consult a stockbroker or a newspaper to determine the stock's market value as of the day of application or redetermination. Document the case record with the following information:

- Date the contact was made or the date of the newspaper,
- Name of stockbroker or name of newspaper consulted,
- Price quoted.

The client can substantiate a lower value by presenting written confirmation of a lower price from a local securities broker.

Mutual Fund Shares

A mutual fund is a company that buys and sells securities and other property. The current market value of the shares in the mutual fund owned by the client is a countable asset unless the client can establish a lesser value. Accept written verification of ownership from the mutual fund company or see the shares themselves. Determine the market value by consulting a stockbroker or a newspaper to verify the closing price on the stock market as of the day of the application or redetermination. Document the case record with the following information:

- Date the contact made, or date of newspaper
- Name of individual or newspaper consulted
- Price quoted.

The client can substantiate a lower value by presenting written confirmation of a lower price from a local securities broker.

U.S. Savings Bonds

A U. S. Savings Bond is a document issued by the government acknowledging that the money has been loaned to it and will be repaid with interest. The current value of a bond, which is its countable value, depends on the length of time elapsed since the date of issue and is subject to fluctuations in the interest rate. The name of the owner of the bond is printed on its face. In addition, some bonds have conversion or "cash-in" restrictions.

Consult a bank to determine the current value of a U.S. Savings Bond and document the case record with the date the contact was made, the name of the person including the name of the banking institution, and the value quoted. Each owner of a U.S. Savings Bond is considered to have an equal share in the value of the bond. If there is more than one owner, divide the total value of the bond by the number of owners to arrive at the amount of each owner's share. Verify the value of the bond at each application, reapplication, or redetermination.

Bonds

- A bond is a written obligation to pay a sum of money at a future specified date (the maturity date) and is a negotiable instrument that is transferable.
- A municipal bond is the obligation of a state or a locality, such as a county, city or town, or a special-purpose authority, such as a school district.
- A corporate bond is the debenture of a private corporation.
- A government bond is an obligation backed by an agency of the Federal government.

- The value of a bond at maturity is its stated value which appears on the face of the certificate. The value of a bond prior to maturity is based on the market for it and may be substantially different than its face value.

- The owner of the bond is the individual who purchased it or to whom it has been transferred and his/her name usually appears on the bond certificate.

- Verify ownership by seeing the bond. Verify the value of a matured bond by its face value. The value of a bond prior to maturity can be verified by a securities broker. Request that the client provide written verification from a securities broker of the current value of the bond. If he is unable to provide this information, contact a broker by telephone or in writing and thoroughly document the case record.

Mortgage, Loan or Promissory Note

The value of a mortgage, loan or promissory note may be a countable asset dependent upon the circumstances, including the individual's role as lender or borrower and the accessibility of the asset.

Definitions

Promissory Note - A written agreement signed by an individual (the borrower) in which he promised to pay a specific sum of money at either a specified time or on demand to another individual, company, corporation or institution (the lender).

Loan - A written or verbal agreement between two parties in which one party (the borrower) agrees to repay money, with or without interest, loaned to him by the other party (the lender).

Mortgage - A security held by the lender on a particular property for the repayment of a debt by the borrower within a particular time period. Land contract, contract for deed, and deed of trust are all mortgages on real property. A chattel mortgage is an agreement using personal property as security for the loan.

Reverse Mortgage

- Description of Mortgage and Reverse Mortgage

  A mortgage is a security held by the lender, on real property requiring repayment of a debt by the borrower within a specified time period. Land contract, contract for deed and a deed of trust are all mortgages on real property. Public Law 105-569 defines a Reverse Mortgage as a loan against the equity in an individual's home that provides cash advances but requires no mandatory monthly re-payment during the life of the loan. If the interest is unpaid, it is allowed to accrue against the value of the individual's home.

A reverse mortgage is similar to a conventional mortgage because the bank does not own the home but holds a lien on the property just as with any other mortgage. The borrower continues to hold the title to the property. The bank cannot demand payment from any family member if there is not enough equity to cover paying off the loan and there is no penalty for paying off the mortgage early.

- Policy for Reverse Mortgage

  The proceeds received from a reverse mortgage are tax-free and available as a lump sum or fixed monthly payment for as long as the individual lives on the property. The loan is not due and payable until the borrower no longer occupies the home as a principal place of residence. When the owner no longer resides on the property, the balance of the borrowed funds is due and payable. After the amount received is repaid, any additional equity in the property belongs to the owners or their beneficiaries.

  When an individual has money in a reverse mortgage line of credit, this money does not count as a loan, or as income or as a resource for Medicaid or TennCare Standard purposes. However, transferring the money to an investment or to a bank account would make the amount transferred a countable resource for Medicaid.

  In order to qualify for a reverse mortgage, the individual must be:

  - at least age 62, and
  - the property must be the borrower's primary residence.

  When money is received from a reverse mortgage:

  - The money that is withdrawn is tax free and does not affect Social Security or Medicare benefits, and can be used for any purpose the homeowner wishes.
  - The money can be received as a lump sum, a line of credit, a monthly payment or any combination of the three.
  - There are no mandatory monthly repayments and the loan can be repaid anytime without penalty.
  - The title of the home does not change.
  - The lender sets the maximum loan amount.

  Client as the Lender

  - Countable Value

    If the client is the lender for a mortgage, loan, or promissory note, he may sell or transfer the instrument to have immediate access to the unpaid loan principal. The value of the unpaid loan principal is a countable asset.

Any subsequent payments to the principal made by the debtor after approval (for TennCare Medicaid) are considered a resource because the unpaid loan principle is a resource. That part of any subsequent payments that represents interest is counted as unearned income in the month received.

- Exclusion

  The value of the loan or note may be excluded from countable assets if the client can demonstrate that the note or loan could not be sold without his realizing a net loss.

  Evaluate the current status of the note at EVERY redetermination. Do not extend benefits pending a demonstration of unsaleability. If, at redetermination, the client cannot provide current substantiation of note unsaleability, close the case if counting the value of the unpaid principle results in resource ineligibility.

- Establishing Value

  The amount of the unpaid balance of the loan (mortgage, personal loan, promissory note, etc.) is the value of the countable asset and must be verified at each application, reapplication, and redetermination. See the written agreement between the two parties and record the following information: date of the agreement, amount of the loan, unpaid balance, interest rate, payment amount, payment breakdown showing principle and interest.

- Client is the Borrower

  The client is considered to have received a loan when he has received a sum of money for which he has a repayment obligation and he expresses his intent to repay the lender. The provisions regarding the countable/excluded value of a loan made to the client depends on the client's intent to repay the loan. A formal repayment agreement is not required, but the client must express his intent to repay the sum.

- Client Expresses Repayment Intent

  If the client is the recipient of a loan, the proceeds are not counted as income or as a resource during the first 90 days following receipt of the funds if the client indicates his intent to repay the loan absent any formal loan, security or collateral agreements. Any amount of the loan retained by the client as a resource after 90 days is a countable asset effective the 91st day following his receipt of the funds.

- Client Does Not Intend to Repay Loan

  If the client does not intend to repay the loan, the proceeds are counted as income in the month of receipt, and any funds retained by the client are a countable asset effective the month following the month of receipt.

- Establishing the Value

  Determine the amount of the loan by contacting the lender or reviewing the loan agreement, if one is available. If the client is the borrower, determine through personal interview the client's loan repayment plans and secure his written sworn statement if he alleges an intent to repay in the absence of any formal loan agreement. If the client intends to repay the loan, set up an Expected Change for the 90th day to determine if he has retained any of the loan proceeds which become countable assets on the 91st day.

Continuing Care Retirement Communities (CCRC's)

DRA added these provisions to cases where entrance fees have been paid to a CCRC or life care communities in order to reside in this community. The Federal Medicaid statue does not define what constitutes a CCRC or a life care community, but it can be a wide range of living arrangements, from independent living skilled nursing care or an assisted living community. In most cases, potential residents must provide extensive information about their finances, including their resources and income, before being accepted for admission. In addition, they usually must pay a substantial entrance fees and sign detailed contract before moving to the community.

Any contractual provision requiring the resident to deposit entrance fees must take into account the required allocation of resources or income to the community spouse before determining the resident cost of care. In addition the entrance fee paid to the CCRC or life care community can be treated as a resource to an individual for purposes of deeming Medicaid eligibility. The following three conditions must all be met in order for the entrance fee to be considered an available resource:

- The entrance fee can be used to pay for care under the terms of the entrance contract should other resources of the individual be insufficient; and
- The entrance fee (or remaining portion) is refundable when the individual dies or terminates the contract and leaves the CCRC or life care community; and
- The entrance fee does not confer an ownership interest in the community.

In order to meet the first condition listed above, it is not necessary for CCRCs or life care communities to provide a full, lump-sum refund or the entrance fee to the resident. If portions of the fee can be refunded or applied to pay for care at the nursing home as required, this condition would be met.

Also, in order to meet the second condition listed above, it is not necessary for the resident to actually receive a refund of the entrance fee or deposit. This condition is met as long as the resident could receive a refund if the contract was terminated, or the resident dies.

NOTE: This policy is effective with the release of this bulletin.

Value of Replacement Resources

For Adult Categories of TennCare Medicaid Individuals, this policy was deleted by Bulletin 14, 4-22-96.

Exclusion

An excluded resource that has been lost, damaged, stolen or destroyed can have cash or in-kind replacement value from any source excluded for a limited time under some circumstances. Exclude as a countable resource the value of the cash or in-kind replacement for repair of lost, damaged, stolen or destroyed excluded resources for up to 9 months beginning with the month following the month of receipt. Interest earned from these funds is also excluded. Examples:

Examples:

- An excluded homestead is destroyed by fire and insurance pays a settlement for a replacement. Exempt as a resource up to 9 months from the date of receipt.

- The only car that belongs to the household is damaged by a storm; the insurance payment is received for repairs. Exempt the insurance payment for 9 months.

The exemption may be extended for a reasonable period up to an additional 9 months if the individual can show good cause why a repair or replacement was not possible during the initial 9 months. Good cause exists when circumstances are beyond the individual's control, i.e.:

- circumstances that prevent repair or replacement. OR

- circumstances keep the individual from contracting for such repair or replacement. NOTE: This policy is not applicable for countable resources or if the value of the asset does not cause ineligibility.

Under certain circumstances the good cause extension for replacement or repair may be extended an additional 12 months after the 18 months expire if:

- there is a presidentially declared disaster (such as with Hurricane Andrew) AND

- the individual still intends to repair or replace the property AND

- good cause still exists.

- If the 18 month extension (9 months + 9 months) has expired and good cause still exists. The exclusion of replacement or repair funds may be extended in what time remains in the additional 12 months.

The total exclusion period may not exceed 30 months beginning with the month following the month of receipt.

EXAMPLE: A presidentially declared disaster due to a flood destroyed an individual's homestead which was also used for farming in 5-94. The $100,000 insurance settlement for replacement of home, farm buildings, tools, and supplies had not been completely spent as of 11-95 (the 18th month), so the TennCare Medicaid case was closed. The individual reapplied in 3-96 and still had not been able to spend all of the replacement funds because flooding reoccurred and the home site had to be relocated with another contractor (the previous contractor went out of business). Since good cause still existed, the replacement funds may be excluded until 10-31-96 (i.e., 30 months total beginning with the month following the month of receipt in 5-94 = 9 + 9 additional + 12 month extension).

Countable Value

The countable value of cash or in-kind replacement of lost, stolen, or damaged resources is a countable asset if the individual cannot provide evidence that warrants an extension and the intent for the use of the funds has changed. Set up a Special Action for 30 days prior to the expiration of the initial 9 months to check if the individual qualifies for additional time. If the evidence does not establish good cause, include the resource in determining eligibility the 10th month following the month of receipt.

TRANSFER OF ASSETS FOR LESS THAN FAIR MARKET VALUE

Legal Base: State Rule 1240-3-3-03 (3) and Sec 6016 of the DRA 2005

Introduction

This policy applies to Institutionalized and HCBS categories only. Transfer of assets policy has evolved through several major changes to the federal law, and this has resulted in implementation of more than one policy at a given time. Two federal laws, the Medicare Catastrophic Coverage Act (MCCA) of 1988 and the Omnibus Budget Reconciliation Act (OBRA) of 1993 previously dictate how transfers that occurred 7-1-88 or later and that occurred 8-11-983 were handled.

The Deficit Reduction Act (DRA) of 2005 currently dictates how transfers are handled. All three acts have in common the method of determining the penalty period and the type of penalty. DRA 2005, however, broadens the spectrum of what is considered a transfer, the length of the penalty period, the look back period for transfers, the definition of assets and how penalty periods run consecutively rather than concurrently.

OBRA 1993 also mandated that certain types of trusts and annuities be considered transfers of assets subject to a penalty under specified circumstances. DRA prohibits disregarding or rounding any fractional period of ineligibility resulting from a transfer of assets for less than fair market value. In determining the penalty period for a transfer of assets, DRA prohibits any rounding down of any fractional month. It also mandates the disclosure and treatment of annuities.

Policy Statement

The uncompensated value of a transferred asset is considered available and countable for the purpose of determining eligibility for TennCare Medicaid vendor payments for long-term nursing care (i.e., institutionalized) individuals in nursing homes and Home and Community Based Services. The penalty for these transfers result in ineligibility for payment of nursing services; however, approval for other medical services may be made if the individual is other wise TennCare Medicaid eligible.

The transfer of assets in exchange for total support and care requires a determination of the monthly support and care contribution from the individual to whom the asset was transferred. This can be found in the Chapter on Income under Unearned Income, "Care and Support Contribution in Exchange for a Transferred Asset" for detailed instructions.

These provisions apply to all institutionalized individuals when the following conditions exist:

- Hardship provisions apply, OR
- The individual can successfully rebut the presumption transfer was made to establish or continue TennCare Medicaid eligibility, OR
- The transfer was made by the individual's legal representative and without the individual's knowledge or consent prior to 8-11-93, OR
- The individual intended to receive fair market value for the transfer, OR
- Effective for transfers made 8-11-93 or later, the asset (i.e., income and/or resources) was transferred to or for the sole benefit of:
    - the individual's spouse or from the spouse to another for sole benefit of the spouse, OR
    - the individual's permanently and totally disabled child, OR
    - was transferred to a trust under certain circumstances, OR

- homestead transferred under certain circumstances, OR

- the transferred asset made 8-11-93 or later, and is returned to the institutionalized individual/spouse negates the transfer penalty. The returned asset is considered to belong to the institutionalized individual and/or the spouse as if the transfer never took place.

Types of Transfer of Assets

The situations listed below are considered transfers of assets and may be subject to a penalty period for institutionalized individuals.

Conveyance for less than Fair Market Value

Giving away or conveying an asset (other than excluded assets) for less than fair market value within the past 60 months (beginning 8-11-93) of an application as an institutionalized individual. (Note: There is a 30 month look back period for transfers occurring prior to 8-11-93.)

Certain Joint Accounts

Establishing joint accounts under certain circumstances.

Irrevocable Trusts

Irrevocable trusts established with the client's own funds on or after 8-11-93 and subsequently within 60 months of application as an institutionalized individual.

Annuities When Expected Returns Are Less than Cost of Annuity

Effective 8-11-93 establishing or purchasing annuities in which anticipated payments based on life expectancy of the individual are less than the cost of the annuity. Effective 2-08-06 the purchase of an annuity may be treated as a disposal of asset for less than fair market value unless the State is named as the remainder beneficiary in the first position. Policy on annuities is explained in detail in the section on Availability of Resources.

Waiving of Entitled Income/Benefits

Actions on or after 8-11-93 involving irrevocable waiving of income or benefits (lump sum payment or rights to a stream of income paid periodically), the individual and/or his/her spouse are entitled to receive.

Waiving an Inheritance

Waiving or giving up an inheritance on or after 7-1-88.

Refusal to take Legal Action to Obtain Child Support/Alimony Not Being Paid

Refusal to take Legal Action for child/support/alimony payments due on or after 8-11-93.

Irrevocable Burial Trusts Under Certain Circumstances

An irrevocable burial fund, trust, or similar device established by the eligible individual or spouse in excess of $6000 is considered a transfer of assets unless proof is provided regarding additional cost for transporting the deceased.

An irrevocable burial trust or similar device established by the funeral home/director is considered a transfer of assets if the cost to the individual or spouse exceeds the value of the merchandise and/or services.

Effective Date Real Property is Evaluated as a Transfer of Assets

The date to consider as the effective date of the transfer of real property is the date the deed is registered with the Register of Deeds.

EXAMPLE: Mrs. Jones quitclaims her homestead to her two sons on 10-15-97. The deed is signed in the presence of a notary that day. The deed is not registered until 7-2-04. DHS must use the date the deed is registered as the point in time to begin any count for a penalty due to transfer for less than fair market value.

In the A.G. Opinion 04-161, "failure to register a deed of conveyance for real property meant that such transfer has not occurred, and that the property is still owned by the seller". Therefore, if the property has not been registered with the Register of Deeds' office, it is still owned by its original owner. The 36-month look-back period for the purpose of when to begin a penalty count is the date the deed is registered.

The caseworker may need to contact the Register of Deed's office for the county where the land is located to determine if a reported transfer of real property has been recorded. The caseworker may also check how the deed is registered at Tennessee Property Data home page at http://170.142.31.248/. This proof will determine when or if ownership status of the real property has changed.

Definitions Pertinent to Transfer of Assets Provisions

- **Assets** - Assets prior to 8-11-93 refers to resources only which include but are not limited to cash, bank accounts, stocks, bonds, real estate, etc. Assets as of 8-11-93 on refers to income, as well as resources, when determining the total uncompensated value transferred.

- **Equity Value** - The price that an item can reasonably be expected to sell for on the open market in a particular geographic area less any encumbrances.

- **Hardship** - Hardship for transfer of asset is considered to exist if the institutionalized individual and/or his/her spouse has no available assets (other than the uncompensated value) in excess of the resource limitations and application of the penalty will result in loss of essential nursing care to the individualized individual which is not available from any other source.

In addition to the above, the DRA of 2005 permits the facility in which the institutionalized individual resides to file an undue hardship waiver application on behalf of an individual, who would be subject to a penalty period resulting from a transfer of assets. Before filing the application, the facility must have the consent of the individual or the individual's representative payee. In addition to filing an undue hardship waiver application, the facility may present information on behalf of the individual to the State and may with the specific written consent of the individual or the individual's representative payee, represent the individual throughout the appeal process.

DRA 2005 allows a bed hold, while the undue hardship waiver is pending. Bed hold days are the responsibility of the Bureau of TennCare. Bed holds may be up to 10 days.

The DRA further provides for the following provisions;

- Send a notice to the individual that an undue hardship exception exists;
- Notify the patient within 30 days if the hardship exception has been granted and
- If there is an adverse action, notify the patient and/or RP, the action may be appealed within 40 days of the notice.

NOTE: The undue hardship waiver, if accepted does not relieve any Personal Representative, Executor, Attorney or any other person from any criminal or civil liability arising out of fraud. This waiver is not a grant of immunity from criminal or administrative recovery of debts arising from fraud.

NOTE: This policy is effective with the release of this bulletin.

NOTE: If the community spouse has available assets, he/she is legally obligated for support of his/her spouse; therefore, hardship does not exist. Hardship for established trusts may exist also if:

- The funds in the trust have been, or are being used on necessities such as clothing, food, and shelter, the loss of which was caused by a natural or casualty disaster, and such losses are not covered by any third party coverage.
- The funds in the trust have been or are being used on funeral or burial expenses of an immediate family member.
- The funds in the trust have been or are being used to prevent or rectify a situation which endangers the health and well-being of the applicant/recipient or his/her immediate family.

- **Legal Representative** - For purposes of this material, legal representative means guardian conservator or one who has the individual's power of attorney. Effective 10-1-93 for transfers occurring on or after 8-11-93, legal representative includes any court or administrative body or any person acting on behalf or at the request of or direction of the institutionalized individual or his/her spouse.

- **Sole Benefit of a Transfer** - Sole benefit of a transfer to someone other than a spouse or child (minor or disabled adult child) for the benefit of the spouse or child in which no one else can benefit from the transfer at anytime.

- **Transfer** - Transfer means the sale, exchange, donation or divestiture of a liquid or non-liquid asset including the exchange of an asset for one of less value, e.g., transfer of real property in exchange for a life estate in it.

- **Uncompensated Value** - The uncompensated value of an asset is the difference between the client's equity in the resource at the time of transfer and the compensation he received in the transaction.

- **Institutionalized Individual** - An institutionalized individual for application of transfer of assets policy is one who has been continuously confined as a patient in a nursing facility or in HCBS. It does not include a hospitalized individual unless payment is made based on a level of nursing care (i.e., Level 1 or Level 2 formerly LCF or SNF care). Individuals in ICF-MR are not subject to the transfer of assets penalty provisions.

  Effective 10-1-89, this term also applies to the community spouse for transfer of assets that take place on or after that date.

  Effective 10-1-93 for transfers occurring on or after 8-11-93, this term includes the institutionalized individual's spouse, legal representative including a court or administrative body, or any person acting on behalf or at the request of or direction of the institutionalized individual or his/her spouse.

Policy Application and Penalties

Non-institutionalized Individuals/Couples applying before, on or after July 1, 1988

NOTE: This policy has timed-out and no longer applies. There is no penalty for transfer of assets since 6-30-88 for non-institutionalized individuals.

Institutionalized Individuals/Couples applying on or after July 1, 1988 and Resources Transferred Prior to August 11, 1993

Resources transferred prior to July 1, 1988, by an institutionalized individual/couple who applied for TennCare Medicaid before, on or after July 1, 1988, will not have any transfer of assets penalty applied unless a penalty period was previously established and has not expired at the time of application.

Resources transferred on or after July 1, 1988 and before 8-11-93 by an institutionalized individual/couple who applies for TennCare Medicaid on or after July 1, 1988, and subsequently any transfers within 30 months of applying for TennCare Medicaid, shall have included as a countable resource the uncompensated value of any asset (unless otherwise excluded) which was transferred for less than the fair market value. This provision also applies to any active institutionalized case who transfers a resource for less than fair market value on or after July 1, 1988 and before 8-11-93 regardless of when an application for assistance was filed. Effective 7-1-88 and ongoing, countable assets for this provision apply to real and personal property except a home transferred to the individual's:

- Spouse;
- Minor child under age 21; OR adult disabled or blind child;
- Sibling who has equity interest in and has resided in the home for at least one year prior to the individual's institutionalization;
- Child (other than above) who resided in the home at least 2 years immediately preceding the individual's institutionalization and who provided care that permitted the individual to stay in the home rather than a medical or nursing facility; OR
- To another for the sole benefit of the community spouse or those individuals described above. The community spouse must not transfer such resources to another person other than the spouse for less than fair market value.

The penalty period for transfers on or after 7-1-88 and before 8-11-93 will be the lesser of the uncompensated value of the transferred asset divided by the average monthly private rate nursing home charge as follows:

- $2,190 per month effective 10-1-01 to 6-30-93
- $2,215 per month effective 7-1-93 through 8-10-93, OR 30 months maximum penalty period,

- $3,394 per month effective 10-1-01
- $3,874 per month effective 7-1-05
- Unless hardship provisions as established apply or a condition applies as above.

The penalty is that the individual will be ineligible for nursing service vendor payments and/or HCBS only, but may receive other medical services if otherwise eligible.

Transfer of Assets 8-11-93 but prior to 2-08-06 by Institionalized Individuals

Policy

A transfer of assets (i.e., income and/or resources) for less than fair market value by an institutionalized individual or his/her spouse beginning 8-11-93 and subsequently within 36 months (60 months of establishing an irrevocable trust with an individual's own assets) of application as an institutionalized individual will result in ineligibility for long term nursing care services in nursing facilities and HCBS. The penalty also applies if the transfer or establishment of an irrevocable trust was completed by a person, including a court or administrative body, with legal authority to act on behalf or in place of the individual and/or his/her spouse or any of these entities acting at the direction or request of the individual and/or his/her spouse and for other types of transfers as outlined above, including transfer of the home except as indicated above.

Penalty Period

The penalty period for assets transferred on or after 8-11-93 may begin no earlier than 10-1-93, but will contain the total number of penalty months as determined directly below. The penalty for transfers on or after 8-11-93 is determined by dividing the uncompensated value of the transferred asset by the average monthly private nursing home charge as follows:

- $2,215 per month effective 9-11-93 to 9-30-94
- $2,519 per month effective 10-1-94 to 2-28-96
- $2,572 per month effective 3-1-96
- $3,394 per month effective 10-1-01
- $3,874 per month effective 7-1-05
- With no maximum penalty period.

There is no limit on the maximum number of months of ineligibility. The penalty continues until expired regardless of whether the individual remains institutionalized. Penalty months must run consecutively rather than concurrently. Any additional transfer of assets will result in a consecutive (rather than concurrent) period of ineligibility. Any uncompensated value from multiple transfers is added to the initial uncompensated value if penalty periods overlap to determine the consecutive penalty period.

EXAMPLE: Mr. Denning gives a non-homestead farm (valued at $80,000) to nephews in 11-93. In 4-94, he gave stocks valued at $15,000 to these nephews. He applies as a nursing home patient in 7-94. Since the penalty for the 11-93 transfer is still in effect at the time of the second transfer, the total value of $95,000 ($80,000 = $15,000) is divided by the private nursing home rate to determine the penalty period for vendor ineligibility.

Transfer of Assets on 2-08-06 or later

The DRA changed the look back period from 36 months to 60 months for any asset transferred for less than fair market value on or after February 8, 2006. It also changed the start date of the penalty. In addition, for assets transferred on or after February 8, 2006, the period of ineligibility will start on the date on which the individual is eligible for medical assistance under the State Plan and is receiving institutional level of care services (based on an application for such services) that, were it not for the imposition of the penalty period, would be covered for Medicaid.

The penalty period cannot begin until the expiration of any existing period of ineligibility. The penalty period will continue to run for the number of months determined by dividing the total value of assets transferred within the look-back period by the average monthly private pay rate. Once the penalty period is imposed, it will not be tolled (i.e., will not be interrupted or temporally suspended), but will continue to run even if the individual subsequently stops receiving institutional level or care.

If a penalty period is imposed on an applicant, a denial for vendor payment notice is required. If a penalty period is imposed on a Medicaid eligible individual, a 10-day adverse action notice is required.

Partial Month Transfers

DRA prohibits the rounding down or disregarding fractional periods of ineligibility, a partial month penalty period must be impose even in the case of smaller asset transfers, where the period of ineligibility would be less than a full month. In imposing penalties on such transfers, if the calculation of the penalty period produces a fractional amount, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average private pay rate used to calculate the penalty.

Calculation of the Penalty Period

John Smith gave a CD valued at $55,000 to his nephew on February 14, 2007. Six months later on August 6, 2007 he enters the nursing home and applies for Medicaid. He is determined to be otherwise eligible except he reported he gave his nephew a $55,000 CD on February 14, 2007. Using the average private pay rate of $3,874 Mr. Smith will not be eligible for Medicaid until September 1, 2008. (This example does not include the partial month, but have assessed a 14 month penalty period).

Mr. Smith leaves the nursing home after 3 months and returns March 2, 2008. Mr. Smith long-term care cost cannot be paid by the State prior to September 1, 2008. The penalty period for the uncompensated transfer will run consecutively regardless whether his confinement was continuous.

However, any penalty period imposed after 2-08-06 would subject to the partial months penalty.

In the State of Tennessee the average private pay rate (currently $3,874) is used to determine the length of the penalty period in which an individual serves for a transfer of an uncompensated asset.

In order to assess a transfer penalty period, the uncompensated transfer amount is divided by the average private pay rate to determine the number of months an individual is responsible for his cost of care, any remainder is divided by the daily rate to determine additional penalty days.

Penalty Period including a Partial Month

Example: An individual transfers $30,534 on April 1, 2007 and applies for Medicaid the same day. The amount transferred $30,534 is divided by the average private pay rate $3,874 to determine the penalty period, which equals to 7.8 month. The seven full months would begin April 1, 2007 and end on October 31, 2007. In order to determine the partial month penalty, the calculations would be as follows:

Step 1	$30, 534	Uncompensated transfer
	÷ $3,874	Average monthly private pay rate
	= 7.8	Number of penalty months
Step 2	$3,874	Average monthly private pay rate
	× 7	Seven month penalty period
	=$27,118	Penalty amount for seven full months
Step 3	$30, 534	Uncompensated transfer amount
	- 27,118	Penalty for the full seven months
	3,416	Partial month penalty amount
Step 4	$3,416	Partial month penalty amount
	÷ 129.10	Daily rate
	= 26	Number of days for partial penalty

This individual would be ineligible for Medicaid for seven month and 26 days. The penalty period would be from 4/1/2006 until 11/26/2006.

NOTE: If an individual is otherwise Medicaid eligible, except for the imposition of a penalty period, Medicaid covered services must be provided.

NOTE: Effective with the release of this bulletin, applicants who have transferred assets on or after February 8, 2006, will have their transfers evaluated under the criteria mandated by the DRA 2005. The penalty period will begin the date the individual is otherwise eligible for institutional level of care under a Medicaid approved State Plan.

EXAMPLE: Applicant applies 08/01/07 and is determined otherwise eligible except he transferred property on 2/9/07. The penalty period would begin 08/01/07 because this is the first month he was otherwise eligible.

Same Scenario: Recipient came in for review on 08/01/07 and reported he transferred his homestead on 2/9/07. His penalty period would begin 2/9/07 because he was otherwise eligible on 2/9/07. Since he was currently eligible, please prepare an overpayment claim for 2/07 until present because a penalty period cannot be retroactive.
Please remember this is only effective for transfers made on or after 2/8/06. Any penalty imposed on or after 02/08/06 would run continuously without interruption, regardless if the individual remained eligible or not.

EXAMPLE: If the penalty imposed on the recipient was 14 months, he would be ineligible beginning 2/9/06 until 03/09/07.

Uncompensated Value of Transfer is Less Than Average Nursing Cost at Private Rate

No penalty applies when the uncompensated value of a transferred asset is less than the average nursing cost at the private rate unless:

- It occurs during a penalty period in which case the uncompensated value is added to the total overlapping values and recomputed, OR
- The individual transfers his/her rights to a stream of income/entitled benefits.
- The cumulative value of all uncompensated transfers made within the look-back period is added together as a single transfer.

Return of Transferred Asset

If the entire transferred resource is returned in the same month, the period of ineligibility does not apply. To meet this exception, the individual must reacquire the same percentage of ownership interest in the resource that existed prior to the original transfer. Reacquiring physical possession of the resource is not sufficient to meet this exception. Merely reacquiring physical possession of the resource is not sufficient, it is necessary to reacquire legal ownership.

Less Than the Entire Resource Return

If the entire resource is not returned, the period of ineligibility does not end, re-compute the uncompensated value based on the adjusted uncompensated value. If additional funds are subsequently returned, it will be necessary to re-compute the uncompensated value again.

NOTE: The return of the resource to the individual is not counted as income to the individual.

Waiving of Entitled Income Benefits

When a single lump sum of income is transferred for less than fair market value, calculate the penalty based on the total lump sum divided by the average private pay nursing home charge. If the amount of the uncompensated value is less than the average private pay nursing home charge, no penalty is imposed.

If a stream of income (i.e., income paid on a regular basis such as a pension or other benefit) is transferred to another for less than fair market value, determine the approximate value of the income to be received during the individual's life expectancy (see Life Expectancy Tables in Appendix A). Divide the anticipated total of transferred income by the average private pay nursing home charge to determine the penalty period beginning with the month of transfer.

EXAMPLE: Mrs. Dale, age 67, is entitled to a royalty payment of $200 per month or $2500 per year, but she has transferred that right to her nephew. At age 67, Mrs. Dale has a life expectancy of 17.48 years x $2500 year = $41,952 uncompensated value divided by average private pay nursing home charge equals number of months of penalty.

Supplemental Security Income (SSI) Recipients (Effective 7-1-88)

SSI individuals living in the community have eligibility determined by the SSA; therefore, DHS is not responsible for resource determination, transfer information, etc. for those individuals.

SSI individuals who become institutionalized for at least 30 consecutive days in a medical institution and/or HCBS or for individuals applying to enroll in HCBS, the individual is determined to need and to be likely to receive services for a continuous period of at least 30 days going forward must have a resource determination made when application is filed at the DHS office. Once the SSI-Termination lawsuit is settled, the same resource transfer policies will apply to these SSI individuals who become institutionalized after 9-29-89 as apply to non-SSI recipients who enter long term care. Meanwhile, please keep a file on those individuals referred by the state office to the county office as having transferred an asset for less than fair market value. A listing of SSI transfers is maintained also in the TennCare Medicaid Policy Unit in the state office.

How to Determine if a Transfer Took Place

Provisions Applying to Jointly Held Assets

Jointly owned assets which reduce or eliminate an asset for an institutionalized individual are transfers of assets. Examples of transfers are as follows:

- An individual is added to an "and" account and the new owner refuses to sign for a withdrawal of funds which results in a reduction of once available assets OR
- Removal of an institutionalized individual's name from an account he/she previously co-owned, OR
- An addition of a joint owner who removes funds from the account.

To determine if a transfer took place under these conditions, evaluate the evidence and ask these questions:

- How long has the asset been jointly owned?
- Who contributed the largest share to purchase the asset; e.g. whose deposited funds made up the bank account?
- Why did the joint owner transfer the asset?

Transferred Executed by an Ineligible Responsible Relative or Others

The transfer of an asset prior to 10-1-89 by an ineligible financially responsible relative (spouse or parent) does not constitute a transfer of assets by the client unless he was part owner of the asset AND he participated in the transfer.

Effective 10-1-89, transfer of an asset by a community spouse may be a transfer of assets and result in a penalty for the institutionalized individual.

Effective 10-1-93, transfers made 8-11-93 or later by the institutionalized individual, the community spouse, legal representative including a court or administrative body at the request of, or direction of or behalf of the institutionalized individual or community spouse may result in a penalty for institutionalized individuals.

Asset Exchange Conversion

Exchange - The exchange of one asset for another is not a transfer provided the client received fair market value for the exchanged item. The exchange of a countable asset for one which is excluded is not a transfer of assets as long as the client remains the owner., e.g., the client exchanges $1000 cash surrender value of life insurance for an irrevocable burial arrangement of the same value.

Conversion - The conversion of one asset for another is not a transfer of assets provided the client receives fair market value in the exchange, e.g. the client uses $1500 cash to purchase an automobile valued at $1500.

What to Do After a Transfer Determination

- Transfer Took Place - If it is determined that a transfer took place, follow instructions above.

- No Transfer Occurred - If it is determined that a transfer has not occurred, document the case record with the decision and the reasons upon which it is based.

How to Determine if the Transferred Asset was Excluded

Certain types of resources are excluded by law, some unconditionally and others based upon their use or intended use.

Types of Excluded Resources Transferred With No Penalty

Funds in an irrevocable burial agreement or trust of $6000 or less for burial purposes are an excluded resource that can be transferred with no penalty. Funds in excess of $6000 may be considered a transfer of assets unless the additional amount is designated for transporting the deceased to another city or state.

A home transferred as outlined above on or after 7-1-88 and ongoing is an excluded resource transferred with no penalty.

Excluded Resources Requiring Transfer Information

Transfer of the following resources must be evaluated in accordance with transfer of assets provisions. The initial exclusion of these resources was based on their use or intended use and a transfer voids the exclusion.

- burial spaces excluded based on their use or intended use
- real property excluded as property essential to self-support or as a homestead.

Determining Fair Compensation

The individual who transfers an asset and receives fair compensation in the exchange has not transferred an asset to establish TennCare Medicaid eligibility and is not subject to any penalties. If the transfer results in the individual's receipt of less than the asset's fair market value in the exchange, presume the asset was transferred to establish eligibility for TennCare Medicaid benefits unless one of the following applies:

- The client can rebut either of the transfer presumptions: transfer to attain TennCare Medicaid eligibility or receipt of fair compensation. OR

- The transfer was executed by the client's legal representative, other than a spouse, without his knowledge or permission prior to 8-11-93. OR

- Hardship is determined to exist for transfers of institutionalized individuals occurring 7-1-88 or later.

The uncompensated value of the transferred asset is counted in determining the period of ineligibility for vendor payments.

Hardship

Hardship is considered to exist if the institutionalized individual has no available resources (other than the uncompensated value) in excess of the resource limitations and application of the penalty will result in loss of essential nursing care which is not available from any other source. NOTE: If the community spouse has available assets, he/she is legally obligated for the support of his/her spouse; therefore, hardship does not exist.

Fair Compensation

Fair compensation is equal to or greater than 100% of the fair market value of the asset. The fair market value (FMV) of an item is the value the item can reasonably be expected to sell for on the open market. Compensation may be in cash or in-kind.

In-Kind Compensation

In-kind compensation is limited to agreements of support and/or maintenance. Compensation in the form of support and/or maintenance is acceptable if the individual can provide verification of the value of the in-kind compensation in written documentation form including cancelled checks, receipts, etc.

Transfer for Total Support and Care

A transfer of assets in exchange for total support and care requires a determination of the amount of the monthly support and care contribution available to the client from the individual to whom the asset was transferred.

Transfer for Lifetime Medical Care

If the individual has transferred assets to a facility or organization in exchange for lifetime medical care, he may not be eligible for TennCare Medicaid benefits.

Unfair Compensation

An individual is considered to have received unfair compensation in a transfer if the amount he receives is less than 100% of the market value of the asset. An individual who transfers real property and retains a life estate has not received fair compensation unless additional compensation plus value of the life estate equals 100% the market value of the asset.

Rebuttal of the Transfer Presumptions

The client may rebut one or both of the following presumptions regarding a transferred asset:

- The transfer was executed to establish eligibility for TennCare Medicaid benefits.
- The individual received inadequate compensation, i.e., less than FMV in the transfer.

Rebuttal of the Transfer to Establish TennCare Medicaid Eligibility

The individual has the right to rebut the presumption that the asset was transferred in order to establish TennCare Medicaid eligibility. He must present convincing evidence that the transfer was executed solely for some other purpose and that TennCare Medicaid eligibility was not a factor in his decision.

Request substantiating evidence and a written statement from the client that includes the following:

- The individual's reasons for transferring the asset.
- The individual's attempts to dispose of the asset for its fair market value.
- The individual's reasons for accepting less than the fair market value in the exchange.
- The individual's cooperation in timely reporting and/or providing needed information regarding the transfer.

Evaluation of Evidence

Evaluate the client's evidence carefully and consult a supervisor keeping in mind the following considerations:

- Did the client make an effort to obtain a fair price?
- What was the timing of the transfer? Was it before he knew about TennCare Medicaid and/or the program's resource limitation, or did the transfer take place just before he applied or just after he was advised of his ineligibility due to excess resources, or were the assets unreported and later transferred after eligibility was established based on

erroneous information provided by the applicant or his/her responsible/legal representative?

Regarding the compensation he received:

- What percentage of the real value did he receive?
- Why did he accept less than the FMV?
- Are the reasons he accepted less than FMV supported by factual evidence and was his action justified?

Rebuttal of the Inadequate Compensation Determination

The client can rebut the determination that he did not receive fair compensation for his transferred asset.

Request a written statement from the client that includes a description of his attempts to dispose of the asset for its FMV AND his reasons for accepting less than the FMV.

Request that the client provide written documentation from at least two knowledgeable sources familiar with the type of transferred asset, e.g. real estate agents, that contains the specific reason(s) the transferred resource could not be sold for its fair market value OR a statement that indicates that the price the individual realized in the transaction was justified under the circumstances.

If the client is successful in his rebuttal of either of the above assumptions, do not count any uncompensated asset value as an available asset in determining his eligibility. Document the electronic case record with a thorough explanation of the decision and the facts upon which it is based.

If the client is unsuccessful in his rebuttal, consider the uncompensated value of the transferred asset in the eligibility determination.

Transfer Executed by the Client's Legal Representative

Transfers prior to 8-11-93

A transfer executed without the client's permission or knowledge by his legal representative is not considered to be a transfer of assets by the client except a transfer by the individual's spouse on or after 10-1-89.

For purposes of the application of this policy, a legal representative includes: a conservator, guardian, or an individual with the client's power-of-attorney.

1. Determine if this Provision Applies

   Determine if the client has a legal representative as defined above and if the representative executed the transfer. Determine if the client cooperated in any way or had knowledge of the transfer. Ask these questions:

   - Did the client initiate, request, or suggest the transfer?
   - Did he cooperate in any way?
   - Did he attempt to prevent the action but his disability/incapacity (supported by medical evidence) prevented his doing so?

   If it is determined that the client (or his spouse effective 10-1-89) had knowledge of or cooperated in the transfer, the uncompensated value (if any) is counted as an available asset in compliance with the policy statement in this section. Apply the provisions and penalties detailed.

   If it is determined the legal representative transferred the asset without the client's (or his spouse on or after 10-1-89) knowledge or permission, the uncompensated value (if any) is not considered part of the individual's countable assets. Advise the client and his legal representative of the following facts in writing:

   - Tennessee State Law (TCA Section 71-5-106) mandates that such transfers are considered to be in defraud of the state.

   Currently the uncompensated value is not considered an available asset and the individual is eligible for benefits and will be approved within 10 working days.

   Unless the asset is returned to the client before the case is approved or within the next 20 working days whichever is longer, a court of competent jurisdiction may set aside the uncompensated asset as being in defraud of the state upon motion of the State of Tennessee or of any party representing the owner of the resource, unless the person holding the power of attorney proves by a preponderance of the evidence that the sale or gift was exclusively for some other purpose than the establishment or continuance of Medicaid eligibility.

   If there is no response to the above from either the client or his representative, take approval action. Refer the case to the DHS District Office where it will be reviewed and referred to the attorney assigned to the District for the consideration of legal action. Send copies of all pertinent documents and correspondence, statements, and evidence related to the transfer action.

Transfers on 8-11-93 or Later by Legal or Appointed Representative

A person including a court or administrative body with legal authority to act on behalf or in place of the institutionalized individual or his/her spouse, or any person including a court or administrative body acting at the direction and/or request of the individual, or his/her spouse who transfers assets belonging to the individual and his/her spouse may cause a penalty for the institutionalized individual.

Penalty Period

If it is determined that a transfer has occurred and that the client received less than fair market value in the exchange, the following action must be taken:

Determine the uncompensated value

To calculate the amount of the uncompensated value, subtract the amount the client received in the transaction from the full value of the asset which is the FMV of the transferred asset (the FMV was previously determined when it was decided if the individual received fair compensation). FMV (FV) – Compensation Received = Uncompensated Value. Round the result to the nearest whole dollar.

If the client alleges that part or all of his compensation is in-kind, attach a dollar value to the support and/or maintenance and subtract that value from the FMV as shown above. If the client alleges he has an agreement for total support and care from the individual to whom he transferred the asset, determine the monthly amount of the support and care contribution. If the individual has transferred an asset in exchange for life-time medical care, he may not be eligible for TennCare Medicaid benefits.

Determine the Penalty Period

During the penalty period, the individual is not eligible for vendor payments for nursing services in long term care facilities or under HCBS, but may receive coverage for other medical services if other wise eligible.

- Transfer of Assets Occurring 7-1-88 to 8-10-93

  The uncompensated value of the transferred asset is divided by the average monthly nursing home private rate in determining vendor payment eligibility for a specific length of time, called the penalty period. The maximum penalty period is 30 months. The uncompensated value of a transferred asset is considered an available and countable resource throughout the month in which the transfer took place. The Penalty Period begins the month in which the transfer occurred. The uncompensated value continues to be considered a countable resource through the last day of the final month in the penalty period.

- Transfer of Assets 8-11-93 until 2-07-06

  The uncompensated value of the asset (income and/or resources) is divided by the average monthly nursing home private rate to determine the penalty period. There is no limit on the number of months in the penalty period. The penalty period begins with the month of transfer, or at the end of a penalty period previously established in which periods of ineligibility would overlap. Penalties cannot begin prior to 10-93 but run the entire number of months as calculated above. The penalty periods are consecutive rather than concurrent when more than one transfer occurs at different times or a transfer occurs during a current penalty period. The penalty period continues until expired regardless of whether the individual remains institutionalized except as indicated below.

  There is no maximum penalty period for transfers occurring on or after 8-11-93. The penalty ends when all penalty periods served consecutively have expired.

  When more than one transfer takes place and penalty periods overlap, combine the total uncompensated value of all transfers and divide by the average nursing home charge at the private pay rate. The penalty period begins the month of the initial transfer.

  Spousal Transfer Causes Penalty for Institutionalized. If a spousal transfer results in a penalty for the institutionalized individual and the spouse becomes institutionalized during the established penalty period, the remaining penalty months must be apportioned between both spouses.

  EXAMPLE: Mrs. Carver enters a nursing home in 12-93. A 36 month penalty beginning 10-93 was assessed due to a transfer by Mr. Carver, the CS. In 8-94, Mr. Carver goes into the nursing home and requests TennCare Medicaid beginning 8-94 (the 11th month of the penalty period). In 8-94, the remaining penalty period of 26 months (including the month of 8-94) is apportioned between both spouses giving each 13 penalty months to 8-95. During his penalty period, no nursing home vendor payment is paid for either spouse.

  If one spouse dies or is discharged from nursing care, the total penalty period remaining for both spouses must be served by the spouse receiving nursing services.

  EXAMPLE: Mr. Carver, in the above example, is discharged to his home in 1-96 (after 6 of his 13 penalty months). The remaining 7 months penalty period would be added back to Mrs. Carver's penalty giving her a new total of 14 months penalty.

Inform the Client of Your Decision

Before taking any action on the application, i.e. approval, closure, continuation or rejection, contact the client in person (face to face interview or by telephone contact or failing that by mail) and give him the following information:

- The decision regarding the transfer.
- Identification of the transferred asset.
- The amount of the uncompensated value.
- The impact on the client's resource eligibility.
- The length of the penalty period.
- The client's rebuttal rights and those procedures.

Allow the client 10 days to respond with an indication of his rebuttal intention If he does not respond, take the appropriate action observing standard advance notification procedures. Document the contact in the electronic case record.

Life Care Contracts

If the individual has transferred his available assets to a facility or organization in exchange for full medical care in the institution for life, the individual is not eligible for TennCare Medicaid benefits unless the contract is determined to be unenforceable.

A contract is unenforceable when the facility is unable to fulfill its responsibilities to provide full medical care and all terms of the contract are void. The facility has a legal obligation to refund any of the client's remaining assets. Should the individual reapply for TennCare Medicaid, these refunded assets would be counted in determining his financial eligibility.

NON-LIQUID ASSETS

Real Property

Real property is any buildings and/or land, improved or unimproved, including burial plots, recreational, residential, or commercial property, and the value of a mobile home.

Countable Value

The equity value in all real property the client owns individually or jointly is a countable asset with the following exceptions:

- Property excluded as homestead
- The inaccessible equity value of real property
- Equity value of income producing property
- Value of certain burial spaces for adult categories

Establishing Ownership and Value

An individual may acquire property in several ways, e.g. through purchase, trade, inheritance, etc. and as a result there are several types of ownership arrangements to explore. This item discusses the following types:

- Ownership by title
- Ownership by life estate
- Ownership through dower/courtesy rights or descent of homestead
- Ownership in an unprobated estate

Ownership by Title

Sole Ownership - The client is the only individual who owns the property and its sale or transfer is not subject to the approval of others.

Tenancy-in-Common - Each owner has an undivided interest in the whole property and can sell his own interest without the consent of the other owner. Upon the individual owner's death, his share passes directly to his heir(s).

Joint Tenancy - Each owner holds an individual interest in the whole property and can sell his or her interest at any time without the consent of the other owner(s). If specifically stated in the deed, the interest of one owner at his death will automatically pass to the other owner. This is the "right of survivorship" and rarely occurs in Tennessee.

Tenancy by the Entirety - This form of ownership can exist only between individuals validly married to each other. Any real property held jointly between a husband and wife is held as "tenants by the entirety" unless the deed specifically states otherwise. The owners are treated as if they were one entity requiring the consent of both owners before any interest can be sold. Upon the death of one owner, his/her interest passes directly to the other owner.

Verifying Ownership by Title

Verify ownership by accepting the client's sworn statement as to property ownership and either the original or copy of a deed, will, or other public record OR telephone or personal contact with the county Register of Deeds who can verify ownership information.

Establishing Value

The countable value of real property is equal to the client's equity value in it. Equity value is equal to the real value of the property less any encumbrances, liens, or other legal claims.

- Real Value

  For program purposes, real value is determined using the property's assessed value which can be easily verified. Assessed value is expressed as a percentage of the real value and, in Tennessee, the ratio is as follows:

TYPE OF PROPERTY	ASSESSED VALUE: REAL VALUE
Farm/residential	25%
Commercial/industrial	40%

  Use the following formula to determine a property's real value:

Farm/Residential:	Assessed value x 4.0 = real value
Commercial/Industrial:	Assessed value x 2.5 = real value

- Assessed Value

  Determine and verify the assessed value by seeing a recent tax assessment notice, contact with the county assessor's office, or written documentation of assessed/real value from the agency responsible for property assessment in another state if appropriate.

  The client has the right to rebut the assessed value, and consequently affect the real valuation. He must provide two written appraisals from two knowledgeable real estate sources, such as a licensed real estate agent, a licensed appraiser, or an appraiser for the VA or FHA that substantiates his claim of a lower assessment. In redetermining the value of the property (after the client's rebuttal), use the higher of the two appraisals. Retain copies of both appraisals for the case record. If the property value is redetermined in this way, give the client the opportunity to present a current alternate valuation at every reapplication or redetermination.

- Equity Value

  To determine the client's equity in a property, subtract the following from the real value:

  - The unpaid mortgage principal, excluding interest

  - The value of any legal lien or claim filed against the property

- The amount of any unpaid taxes excluding current taxes.

The remainder, the client's equity value, is a countable resource. The formula for determining equity value in farm or residential property is:

- Assessed Value x 4.0 = Real Value – Encumbrances = Equity Value

- Special Note on Burial Spaces

  Exclude as a resource the value of burial spaces for family and children's categories. For others, verify ownership and value of burial spaces with the owner and/or management of the cemetery where the spaces are located. The client's equity value is figured in the same way as for other property for which he holds title.

Ownership Through Life Estate

A life estate endows an individual with the legal right to use a property for a specified period of time, usually for the rest of his life and may be obtained through inheritance or reserved by the owner of the property at the time of its transfer. The owner of a life estate is entitled to any income that the property may produce, and the income is deemed available to him whether or not he actually receives it.

Property in which a client holds a life estate is subject to the same exclusions as property he owns by title, e.g., household exemption, property essential to self-support, or exclusion as an inaccessible asset. The life estate may be sold though the owner does not have the legal right to sell or transfer the title to the property. He sells only his use rights and the buyer has the right to use the property for the remainder of the lifetime of the original owner of the life estate.

Upon the death of the owner of the life estate, full title and ownership usually passes to the "remainder man", the individual named in the will or deed as entitled to the property.

In addition DRA of 2005 provides that **unless** an individual purchasing a life estate in another's individual's home actually resides there for a period of at least one year after the date of purchase, the transaction should be treated as a transfer of assets. The amount of the transfer is the entire amount used to purchase the life estate. This amount should not be reduced or prorated to reflect an individuals' residency for a period of time less than a year.

NOTE: This policy is effective with the release of this bulletin.

Countable Value - The entire value of a life estate is a countable asset unless it is excluded as homestead, property essential to self support, or as an inaccessible resource.

Establishing Ownership - Accept only written documentation of ownership such as the will which endowed the life estate or a copy of the deed or other contract which reserved a life estate for the client.

Establishing Value - The value an individual retains in a life estate can be established on-line through the data base. The process used is listed below:

- Verify the cash market value of the property an individual retains in a life estate; enter the amount on the appropriate data base screen; answer yes (Y) to the question, "Is this a life estate?"

- The data base will use the product taken from a table that corresponds with the individual's age found on the appropriate data base screen AND

- The data base will multiply the product by the current market value to arrive at the current value of the life estate.

Dower/Courtesy Rights (Received before 4-1-77)

Descent of Homestead (Received after 4-1-77)

Right to Elective Share (TCA (31-4-101)

The surviving spouse of an intestate decedent who elects against taking an intestate share, or a surviving spouse who elects against a decedent's will, has the right of election, (unless limited by subsection by subsection © of this same title) to take an elective-share amount equal to the value of the decedent's net estate as defined in subsection (b) of this same title), determined by the length of time the surviving spouse and the decedent were married to each other

Share of Surviving Spouse and Heirs (TCA 31-2-104)

The intestate share of the surviving spouse is:

- If there is no surviving debts of the decedent, the entire intestate estate; or

- If there are surviving debts of the decedent, either one-third or a child share the entire intestate estate, whichever is greater.

Countable Value

After the elective-share amount has been determined and all the funeral and administration expenses and all debts by creditors have been secured, any remaining amount is countable to the surviving spouse.

Establishing Ownership

The client's sworn statement of ownership is sufficient verification when property is inherited through dower/courtesy rights or the right of descent of homestead.

Ownership Interest in Unprobated Estate

An individual may inherit an interest in property which he may sell or transfer even though the inheritance has not been legally distributed, i.e. the estate is still in probate.

Ownership interest in an unprobated estate is substantiated by the will which granted the individual his interest.

Deceased died Testate (with a will). Review a copy of the will or request that the client provide a written statement from his attorney itemizing the property in which the client has an interest. Value each item as is appropriate for its classification, i.e. real estate, personal property, motor vehicle, etc. The value is a countable asset unless the client alleges it to be inaccessible, and it is determined the availability of assets provisions apply.

Deceased died Intestate (without a will). Collect the following information and submit it to the DHS attorney assigned to the District with a request for assistance in determining the value and availability of the client's interest in unprobated property.

- Copies of deeds or titles to all properties owned by the deceased.
- Description of other items owned by the deceased, e.g. motor vehicles.
- The client's relationship to the deceased.
- The date of the deceased's death.
- The number of surviving relatives and their relationship to the deceased.

The Homestead Exclusion

Legal Base: 20 CFR 416.1212 and 20 CFR 416.1149
State Rule: 1240-3-3-.03 (2) (a) (1) (i)

Exclusion Provision

The entire value of the home whether on land or water (including a mobile home), all adjoining land not separated by property owned by others, and any related outbuildings are excluded in determining resource eligibility as long as:

- The client's intent to return to the home is established, OR
- The home is the principal place of residence for the client and/or his/her spouse and/or dependent relatives.
- Effective with the release of this bulletin, individuals equity interest in his/her home does not exceed $500,000

NOTE: An individual must have lived in the home for it to be considered his/her home or principal place of residence.

Exclusion of Homestead Due to Intent to Return

The value of the home and surrounding land will not be counted as a resource during the client's absence from an unoccupied home when he/she intends to return to the property.

- Absence from the Home

  The absence from the home is necessary to accomplish a specific purpose such as hospitalization, confinement in a nursing home, or residence elsewhere is necessary to receive services, such as nursing or personal care services not available to the individual in his/her own home.

- Development of Intent to Return

  When the individual is absent from his/her homestead, and it is not occupied by a spouse or dependent relative, determine the intent to return as indicated below at each (re)determination of eligibility.

  - Secure a signed statement from the institutionalized individual of his/her intent to return to the homestead. If the individual is not capable of providing the information, accept the signed statement from an individual authorized to act in the client's behalf.

  - Be sure that the statement gives the client's reason for being absent from the home and whether he /she intends to return.

  - Accept the signed statement without question unless the client's intent to return is unclear or contradictory.

  EXAMPLES:

  During one interview, the client states he plans to go home in a few weeks. He later states his children are coming to the nursing home to visit him on a holiday several months away, and then says he plans to return to his home to harvest his garden by the first of the next month.

  The client states she plans to return home within a few months, and then states she is going on Tuesday to live with her daughter in another state. She later states, during the same conversation, that she will never be able to leave the nursing home.

  Obtain clarification from someone in a position to know the facts (e.g., close relative or physician) when the client's intent is unclear or contradictory.

When the Exemption Period Ends

An intent to return home is nullified by any efforts to sell or dispose of the property during the exemption period. The exemption based on the intent to return ends the first day of the month after the month efforts are made to sell or dispose of the homestead property.

Rental of a homestead which has been excluded because of intent to return does NOT nullify the exclusion. The homestead retains the exclusion as long as there is a clear, non-contradictory intent to return, and no efforts are made to sell or dispose of the property. The rent will be counted as unearned income in the month received.

The exemption based on residence of the client's dependent relative ends the first day of the month after the month the relative last lived in the homestead, if the relative does not intend to return. NOTE: The absence and intent to return provisions also apply to the client's dependent relatives if the home is their principal residence.

Homestead Located Outside Tennessee

Real property located outside Tennessee can be excluded from countable resources as homestead property if there is substantiation of the client's intent to return to the home, OR the property is the principal residence of the individual's spouse or dependent relatives.

Dependent Relative Defined

A homestead retains its exclusion if it is the principal residence of the client or spouse or relative within the specified degree below who is dependent on the client. Dependency may be of any kind (financial, medical, residential, etc.). "Relative" means any one of the following:

Aunt	mother
Brother	nephew
Cousin	niece
Daughter	sister
Father	son
Granddaughter	stepbrother
Grandfather	stepdaughter
Grandmother	stepfather
Grandson	stepmother
Half-brother	stepsister
Half-sister	stepson
In-laws	uncle

Accept the signed statement by the individual's spouse or dependent relative regarding his/her relationship to the client and residence in the homestead without question unless it is contradictory.

Property Essential to Self-Support

Legal Base: 20 CFR §§ 416.1220, 1222 and 1224
State Rule: 1240-3-3-.03 (2) (a) 1(v)

When counting the value of resources an individual or his/her spouse, may have the value of property essential to self-support not counted within certain limits. There are different rules for considering this property depending on whether it is income-producing or not.

When deciding the value of property used in a trade or business or non-business income-producing activity, only the individual's equity in the property is counted. We exclude as essential to self-support up to $6,000 of an individual's equity in income-producing property if it produces a net annual income to the individual of at least 6 percent of the equity. If the individual's equity is greater than $6,000, we count only the amount that exceeds $6,000 toward the allowable resource limit of $2,000 for an individual.

If the individual owns more than one piece of income producing property and each produces income, each is looked at to see if the 6-percent rule is met and then the amounts of the individual's equity in all of those properties producing 6 percent are totaled to see if the total equity is $6,000 or less. The equity in those properties that do not meet the 6-percent rule is counted toward the allowable resource limit of $2,000 for an individual. If the total equity in the properties producing 6-percent income is over the $6,000 equity limit, the amount of equity exceeding $6,000 is counted as a resource toward the allowable resource limit.

Property essential to self-support can include real and personal property for example, land, buildings, equipment and supplies, motor vehicles, and tools etc. used in a trade or business, non-business income-producing property such as houses or apartments for rent, land other than home property, etc., and property used to produce goods or services essential to an individual's daily activities. Liquid resources other than those used as a part of a trade or business are not property essential to self-support.

If the individual's principal place of residence qualifies under the home exclusion, it is not considered in evaluating property essential to self-support.

The Home

The home where equity does not exceed $500,000 is an excluded resource. The individual uses the home property to perform self-support activities Such as farming. However it is a countable resource if the equity exceeds $500,000 and no spouse or dependent relative is residing in the home (Further discussion of homestead property can be found in Section B above).

EXAMPLE: Bill Wright owns a small farm valued at $450,000. He suffered a stroke and was admitted to a nursing home, but has intent to return to his home as soon as he recovers. He grows vegetables and raises cows on his farm which he uses to feed himself and his farm employees. He also sells his crops and beef from the

cows to the market. Because his farm is valued at less than $500, 000, the farm is exempt under the homestead exclusion.

Property excluded as essential to self employment falls into four categories

- Property used in a trade or business.

When property is used in a trade or business or non-business income producing activity, only the individual's equity in the property is counted. Exclude as essential for self-support up to $6,000 in equity and count only the amount that exceeds $6,000, if the net income totals at least 6% of the equity. If the work activity produces less than a 6% rate of return due to circumstances beyond the individual's control such as illness or crop failure and they are expected to resume the activity, the $6,000 equity rule continues to apply. If the individual's total equity in the property is producing 6% income but is over the $6,000 equity limit, the amount of equity exceeding the $6,000 is counted as a resource.

Example 1: Charlotte operates a farm. She owns 3 acres of land on which her home is located. She also owns 10 acres of farm land not connected to her home. There are 2 tool sheds and 2 animal shelters located on the 10 acres. She has various pieces of farm equipment that are necessary for her farming activities. Exclude the house and the 3 acres under the home exclusion However, we look at the other 10 acres of land, the buildings and equipment separately to see if her total equity in them is no more than $6,000 and if the annual rate of return is 6 percent of her equity. In this case, the 10 acres and buildings are valued at $4,000 and the few items of farm equipment and other inventory are valued at $1,500. Charlotte sells produce which nets her more than 6 percent for this year. The 10 acres and other items are excluded as essential to her self-support and they continue to be excluded as long as she meets the 6-percent annual return requirement and the equity value of the 10 acres and other items remains less than $6,000.

Example 2: At redetermination, Mr. Jones states he has rented his formerly excluded homestead which has an equity value of $10,000. Although the property produces a 6% rate of return, $4,000 of its equity cannot be excluded under this provision.

- Property that represents government authority to engage in an income producing activity.

Property that represents the authority granted by a governmental agency to engage in an income-producing activity is excluded as property essential to self-support if it is used in a trade or business or non-business income-producing activity or not used due to circumstances beyond the individual's control and there is a reasonable expectation that the use will resume.

Example 1: John owns a small tobacco farm but is paid by the government not to grow tobacco on this land. The equity value in the farm is $6,000. The government paid John $4,000 not to grow tobacco on his land. Although the government paid in excess of the 6% rate of return of the excluded equity value, the exclusion up to $6,000 still applies.

Example 2: John owns a commercial fishing permit granted by the State Commerce Commission, a boat and fishing tackle. The boat and tackle have an equity value of $6,500. Last year, John earned $2,000 from his fishing business. The value of the fishing permit is not determined because the permit is excluded under the exception. The boat and tackle are producing in excess of a 6 percent return on the excluded equity value, so they are excluded up to $6,000. The $500 excess value is counted toward the allowable resource limit of $2,000 for an individual or $3,000 for an individual and spouse**.**

- Property required by employer

Personal property required by the individual's employer for work is not counted regardless of value, while the individual is employed. Examples of this type of personal property include tools, safety equipment, uniforms and similar items.

- Property used to produce goods or services essential to daily activities.

Non-business property is considered to be essential for an individual's (and spouse, if any) self-support if it is used to produce goods or services necessary for his or her daily activities. This type of property includes real property such as land which is used to produce vegetables or livestock only for personal consumption in the individual's household (for example, corn, tomatoes, chicken, cattle). Property used to produce goods or services or property necessary to perform daily functions is excluded if the individual's equity in the property does not exceed $6,000.

Example: Bill owns a small unimproved lot several blocks from his home. He uses the lot, which is valued at $4,800, to grow vegetables and fruit only for his own consumption. Since his equity in the property is less than $6,000, the property is excluded as necessary to self-support.

Property essential to self-support

Property essential to self-support does not include cash, stocks, bonds, or any other liquid resources described in this Chapter even though these liquid resources may be producing income. The following are examples of the types of assets essential to self-support and a description of their excluded values.

- Specially modified motor vehicle

Exclude the value, subject to the limitation cited in this Chapter of an additional or specially modified motor vehicle required for transportation due to climate, terrain, distance, or similar factors.

NOTE: This exclusion may be applied in addition to the exclusion cited under the "Motor Vehicles" section of this Chapter.

- Resources specified by Rehabilitation Plan

  Exclude the value of any resources belonging to a blind or disabled individual specified in a written plan for achieving self-support (PASS) approved by the Vocational Rehabilitation program or the Blind Services program. The resources specified in the plan lose their exclusion upon completion or failure of the plan. The PASS is a time-limited work plan with an initial period up to 18 months. The time limit may be extended another 18 months not to exceed a maximum of 48 months when additional time is needed to complete training and/or educational requirements.

- Essential Property Not in Use

  Essential property for self-support (i.e., income producing property, tools, equipment), not in current use may retain its exclusion if it has been in use, AND there are reasonable plans to resume use of the property within 12 months of its last use. The 12 month period may be extended for an additional 12 months, if it is in non-use due to a disability condition. Documentation must be recorded regarding the date of last use, the reason(s) for non-use at the current time, and when the individual expects to resume the activity, if at all.

  An Expected Change must be scheduled to determine the status of the non-use and the individual's intention. If use is no longer anticipated, the property loses its exemption the month following the 12th month of the exemption period or the month following the decision not to resume use, whichever is earlier.

Burial Spaces

Exclude the value of burial spaces as a resource for family and children's categories.

For adult categories and institutionalized individuals, the value of burial spaces to the extent of the individual's equity value and any interest accrued thereon is a countable nonliquid resource, unless excluded based on their intended use by the individual and/or members of his family.

Burial Spaces Defined

Burial spaces include conventional grave sites, burial plots, crypts, mausoleums, urns, niches, or other repositories which are customarily and traditionally used for the remains of dead persons. It may also include improvements or additions to such spaces including, vaults, headstone, markers, plaques or burial containers and arrangements for opening and closing the gravesite.

Burial spaces may be held for an individual under contract. If the contract is an installment sales contract, the individual will not own or have the right to use the space until all payments

have been made. Generally, the money paid in can be returned prior to payment in full. In situations like this, the space may not be excluded under burial space exclusions until the contract is paid in full. Funds paid to date on an installment contract are a resource to the individual and may qualify for the Burial Funds exclusion.

Exclusion Provision

Exclude from countable resources the value of burial spaces, and any interest accrued thereon, owned by the eligible individual and intended for his use and/or use by members of his immediate family. Exclude the value of burial spaces owned by the individual's FRR(s) if intended for the use of the individual and/or members of his immediate family.

Immediate family includes the individual's minor and adult children, step-children and adopted children, brothers, sisters, parents, adopted parents, and the spouses of those persons. Dependency and living-in-the-same-household are not factors in applying this exclusion. Immediate family does NOT include the members of an ineligible spouse's family unless they are also members of the client's immediate family.

Applying Exclusion

Specifically identify excluded burial spaces, including at least the space or lot number and the name and location of the cemetery/mausoleum. Secure the individual's written statement clearly indicating for whose use the space(s) is intended, and the person's name and his/her relationship to the individual. Review the exclusion at every reapplication or redetermination.

Motor Vehicles

Legal Base: 20 CFR 416.1210©; 20 CFR 416.1218
State Rule: 1240-3-3-.03 (2) (a) (1) (iii)

Motor Vehicle Defined

Motor vehicle, for purposes of this policy, means any four-wheeled passenger vehicle used to provide necessary transportation owned by any budget group member.

Countable and Excluded Values

Exclude from countable resources the value of one motor vehicle, regardless of its total value, if it meets one of the following conditions:

- The vehicle is necessary for employment. OR
- The vehicle is modified for operation by or for the transportation of a handicapped individual. OR
- The vehicle is necessary transportation to attain medical treatment of a specific or regular medical problem. OR
- The vehicle is necessary because of climate, terrain, distance, or similar factors to provide necessary transportation to perform essential daily activities.

If the vehicle does not meet any of these conditions, exclude up to $4600.00 of its current market value (CMV) from the individual's countable resources. Count all of the vehicle's market value in excess of $4600.00 as a resource.

NOTE: If the CMV of a vehicle is $4600 or less, and it is the only vehicle, it will be totally excluded without considering any of the above total exclusion categories.

Count the equity value of any additional motor vehicle as a non-liquid resource unless the vehicle is excluded under a provision not related to the automobile exclusion, such as a qualified property under a plan for achieving self support, OR resources necessary for self-support as a part of a business or non-business income-producing activity.

When there is more than one vehicle, apply the automobile exclusions in the manner which is more advantageous to the applicant/recipient. Examples: The car of highest value may not be the vehicle used to obtain medical treatment; however, it may be excluded for use, if it is to the advantage of the applicant/recipient. If no vehicle can be totally excluded, compare the CMV and the equity value of the vehicles owned to establish to which vehicle the $4600 exclusion should be applied.

Determining Ownership

Accept the individual's sworn statement regarding motor vehicle ownership (verified by collateral contact). If a question arises, the following are acceptable verifications:

- Automobile registration
- Bill of sale
- Automobile title (individual named here is the undisputed owner)

Establishing the Value of a Motor Vehicle

The Current Market Vale (CMV) of a vehicle is the average price a vehicle of that year, make, model and condition will sell for on the open market to a private individual in the particular geographic area involved. The individual's equity value in a motor vehicle is equal to the vehicle's current market value less any encumbrances, e.g. balance due on a loan, liens, etc.

Use the average loan value in a current NADA Used Care Guide book (or web site) to establish the current market value of an automobile or truck. If the vehicle is not listed in the guide book, and it is 11 years old or older, assume the value is $4600 or less UNLESS it meets one of the following criteria:

- Luxury vehicle such as a Jaguar or a Lincoln.
- Antique vehicle that is over 25 years old.
- Customized.
- Pick-up truck larger than 1.5 ton.

If the vehicle is not listed in the guide book and is less than 11 years old or meets one of the criterions listed above, request estimates of the auto's market value from two reputable auto

dealers. Use the higher estimate to value the vehicle and retain both estimates in the case record.

The client can substantiate a lower value by submitting written statements of the vehicle's value from two reputable auto dealers. Use the higher of the two estimates in determining the vehicle's value and record both estimates in the case record.

Contact a reputable dealer to obtain an estimate of the value of other types of motor vehicles, such as a motorcycle. Document the contact in the case record. The client can substantiate a lower value as described above.

Boat, Snowmobile, Jet Skis and other Recreational Vehicles - The entire amount of the client's equity in this type of asset is a countable resource. Accept the client's sworn statement regarding ownership unless there is reason to question his allegation. Request the type of legal documentation of ownership considered appropriate, including boat registration, bill of sale, title, etc. Contact a reputable dealer familiar with the type of asset in question to determine the item's market value. The client has the right to substantiate a lower value than the one determined.

Household Goods and Personal Effects

Children and Family Categories

Exclude from countable resources the value of all basic maintenance items essential to daily living, such as clothing, furniture, appliances and other similar essential household good and equipment of limited value.

Adult Categories:

Legal Base: 20 CFR 416.1216, State Rule: 1240-3-3-.03 (2) (A) (1) (IV)

- Spousal Impoverishment Cases

  Under Spousal Impoverishment provisions of the Medicare Catastrophic Act (PL 100-360 Section 1924 (5) (B)), there is no limitation on the value of household goods and personal effects.

- Non-Spousal Impoverishment Cases

  This section applies to household goods and personal effects for all adult categories excluding the exception under Spousal Impoverishment provisions.

Definitions

Household goods are furnishings and equipment commonly found in or about a house and used in connection with the operation, maintenance and occupancy of the house including but not limited to such items as furniture and equipment used in the functions and activities of home and family life as well as that used for comfort and accommodation.

Personal property is personal effects such as jewelry, clothing, and items of personal care or individual education.

Excluded and Countable Values

Exclude from the individual's countable resources the value of household goods and personal effects in which the individual's equity value is $2000.00 or less. Exclude from the value of household goods and personal effects the following items:

- One wedding and one engagement ring.
- Goods required because of a person's physical condition such as, prosthetic devices, dialysis machine, hospital bed, etc.

The value of the individual's equity in household goods and personal effects in excess of the $2000 exclusion limit is a countable nonliquid resource.

Establishing Ownership

Accept the client's sworn statement regarding his ownership of items of personal property and household goods unless there is reason to doubt his declaration.

Establishing Value

Describe household goods and personal effects for the client and inquire if one item is worth over $500. (i.e., its current market value). Accept the client's sworn statement as to the value of the personal property and household goods items unless there is reason to doubt his declaration. If the client alleges an item is encumbered, verify the amount of encumbrance to determine the client's equity value.

To determine equity value, apply this formula:

- Equity Value = Declared Value – Encumbrances

If the individual reports ownership of any item worth more than $500, follow this procedure to determine countable value:

- Determine the individual's equity value in each item valued in excess of $500. Accept the client's sworn statement of CMV and verify encumbrances. Subtract the total encumbrances from the CMV of the item to determine the equity value.
- Total the equity value(s) determined and add $1000 (an estimate of the remaining value of the household goods and personal effects).
- Compare the resultant total value to the $2000 maximum exclusion limit. Any amount in excess of $2000 is a countable asset.

Mobile Homes

A mobile home not excluded as homestead property or excluded for any other reason is a countable non-liquid asset to the extent of the individual's equity value.

Establishing Ownership

Accept the individual's sworn statement of ownership substantiated by either a tax assessment notice (most recent one) or the deed, title or other legal documentation of ownership.

Determining the Value of a Mobile Home

- Attached Mobile Home

  Mobile homes which are attached to a foundation, underpinned or connected to any one utility, such as electricity, natural gas or water, are real property and for tax assessment purposes are considered improvements to the land on which they are located. They are assessed at the same percentage rate as the land on which they are located and are listed on the tax notice as part of the landowner's real property whether or not the landowner owns the mobile home.

  If the individual owns the land and the mobile home to which it is attached, he will receive separate tax notices for each. Use the assessed value to determine the CMV and verify encumbrances to determine equity value.

  If the individual is the landowner and alleges the mobile home is owned by another, request that he provide evidence to establish ownership. If it is established that the mobile home is owned by someone other than the client, exclude the mobile home as part of his assets. If, however, the individual is unable to present evidence to substantiate his allegation, assume the mobile home belongs to the landowner.

  Establish through the local tax assessment documents that the individual owns only the mobile home (and not the land to which it is attached). Use the most recent tax assessment notice to determine the assessed value of the mobile home and follow instructions for valuation of real property to determine the individual's equity value.

- Unattached Mobile Home

  An unattached mobile home is not affixed to a foundation, underpinned or connected to one utility (water, natural gas, electricity) and is not an improvement to real property for tax assessment purposes. Unattached mobile homes are usually assessed as personal rather than real property based on 100% of the real value. Contact the county assessor's office to determine the amount of the assessment and its basis, i.e., 100% or less of the real value. If the home is assessed on a percentage of real value, determine the full real value for real property.

  If the mobile home is not assessed as personal property, determine the make, model, or length and model year from the registration or title. Contact a local dealer to determine the home's CMV. Alternative methods of valuation include a review of the purchase records, lien hold record, or the Mobile Home Blue Book (or web site). Once the real value of the mobile home is determined, deduct any verified encumbrances to determine the individual's equity value.

Life Care Contracts

The individual who has transferred his available assets to a third party in exchange for full medical care for life is considered to have entered into a life care contract. Because the individual has a third party medical resource legally responsible for all his medical needs, these individuals are not eligible for TennCare Medicaid benefits. These provisions apply even if the full amount of the individual's assets has been spent by the third party for his care UNLESS the contract between the two parties is void or not enforceable for some reason.

If the individual entered into a contract of more limited scope, i.e., the terms of the contract specified certain medical care limitations, he may be eligible for benefits.

Third Party Defined

For purposes of this policy, third party includes any individual, institution, corporation, or public/private agency liable or potentially liable for all or part of an individual's medical costs.

Enforceable Contract

An enforceable contract does not exist when its terms cannot be fulfilled and are void or rescinded. A contract is rescinded when the third party is financially unable to fulfill its contractual responsibilities. Under these circumstances, the third party is legally obligated to return to the individual any remaining assets from those originally assigned in the contract.

The individual may be eligible for TennCare Medicaid after requiring a financial accounting from the third party of the following:

- The full amount of income and resources originally assigned to the third party by the terms of the contract.
- Total expenses paid and fees charged by the third party.
- The full amount of the refund.
- The full amount of the refund is a countable asset.

Contractual Agreement Limited in Scope

The contractual agreement that is limited in scope, i.e., limited to basic room and board or basic room and board and partial medical services, many not preclude TennCare Medicaid eligibility. Determine the individual's eligibility and review his transfer of assets to the third party as described in the Transfer of Assets section of this Chapter. If the individual is determined to be eligible, TennCare Medicaid reimbursement is available for those items encompassed within the state's plan that are not included in the life care contract. Report the life care contract to the Third Party Liability Unit of the Bureau of TennCare and enter the resource on the data base.

Estate Recovery

Legal Base: 42 U.S.C. 1396p October 1, 1993, TCA 71-5-116(c)(2)

Estate recovery, which is mandated by Federal and State law, means a state may file a claim with a deceased individual's estate for reimbursement of TennCare Medicaid expenditures for nursing home costs. Any TennCare Medicaid eligible individual in a long-term care facility is subject to estate recovery. This definition includes deceased individuals who:

- Were TennCare Medicaid eligible while in a LTCF
- Were age 55 or older
- Have no children under the age of 18
- Have no children who are blind or permanently and totally disabled
- Have no surviving spouse.

The TennCare Estate Recovery Unit is responsible for the estate recovery program. The TennCare Reform Act of 2002 requires a release be obtained from TennCare indicating that 'no money is owed by a former Medicaid eligible individual' before an estate can be settled. A copy of this release form is available on the TennCare web site: www.state.tn.us/tenncare/members/estaterecivert1.htm. Attorneys or relatives may contact for further information:

Bureau of TennCare
Estate Recovery Unit
310 Great Circle Road
Nashville, TN 37243
Telephone 1-866-389-8444
FAX 615-741-0882

DHS is required to inform the responsible party of applicants and recipients in long-term-care facilities about the Estate Recovery provisions. There is a reference to Estate Recovery on page 5 of the DHS application for assistance which says, "If the state pays medical bills or for nursing home care for you, the state may get its money back. When you die, the state may take money from your estate." This should be discussed at application and at each review for individuals applying for or receiving TennCare Medicaid in a long-term-care facility.

CATEGORIES OF ELIGIBILITY

MEDICAID ONLY PREGNANT WOMEN (MA P)

Policy Statement

Medicaid Only Pregnant Woman - An aid group consisting of a pregnant woman only who qualifies otherwise, is eligible for TennCare Medicaid only during the first two trimesters of her pregnancy as a Medicaid Pregnant Woman case, MA P. The pregnant woman may be determined eligible for TennCare Medicaid and FF cash payment during the last trimester of pregnancy, if an application is filed for Families First.

The MA P assistance group is created when the pregnant woman with no other children has made application for the Families First cash assistance program, but she has not yet reached the third trimester of her pregnancy. Families First cash assistance does not provide cash payments until the third trimester of pregnancy. Prior to the third trimester, the client is eligible for Medicaid Only if all technical and financial requirements are met; however, a recipient of Medicaid Only is not required to comply with the work requirement of the Families First program and is not eligible for the associated services.

When the verified date of conception and anticipated confinement is entered into ACCENT, the system calculates whether the pregnant woman is in her first or second trimester of pregnancy. If she is, the MA P group is created. Medicaid Only benefits are authorized as a MA P case until the third trimester of the pregnancy.

The DHS caseworker will receive a case alert from the data base 30 days prior to the beginning of the third trimester. The caseworker will run the appropriate driver on the data base, and at that point, Medicaid Only benefits will continue in the AFDC-MO (MAC) category. Families First policy and procedures are not repeated in their entirety in this Manual. Reference must be made to the Families First Handbook.

SIBLING INCOME MEDICAID ONLY

Policy Statement

Legal Base: State Rule 1240-3-2-.02
1996 Federal Welfare Reforms, Section 1931 of the Social Security Act

This category is commonly referred to by its group name, MA S, or as a "Sibling Income case". MA S is a categorically needy coverage group providing assistance to families with dependent

deprived children and their needy caretaker relatives who are ineligible for AFDC-MO solely because of income from a sibling, including half or step siblings.

These aid groups must meet all the technical and financial requirements of the AFDC-MO assistance program.

AFDC-MO

Policy Statement

AFDC-MO is a categorically needy coverage group which provides Medicaid to child(ren) and their caretaker in the specified degree of relationship when the child(ren) is deprived of parental support. In situations where both parents are absent from the home, and non-parental married caretakers are in the specified degree of relationship, both caretakers if otherwise eligible may elect inclusion in the aid group. The purpose of section 1931 is to allow individuals to apply for Medical assistance based on AFDC eligibility requirements in effect prior to July 16, 1996. The State of Tennessee has elected to make eligibility for AFDC-MO and Families First eligibility as closely related as possible.

Definitions

- *Parental Control* - Parental control is the authority exercised by a mother, father, or any adult household member acting as a parent to guide, manage, supervise, and provide care to a minor dependent child who lives in the same home.

- *Caretaker Relative* - A caretaker relative is considered a caretaker of the children involved and has primary care and control. The case may contain more than one caretaker relative.

- *Stepparents* - A stepparent is not considered a legally responsible relative; therefore, AFDC-MO may be approved for the child of another biological parent who is living with an able bodied parent and a stepparent. The income of the stepparent living in the home will be deemed available to the stepchildren. In addition, the income of a stepparent in the military service and out-stationed will be deemed to the stepchildren (deeming methods can be found in the section of AFDC-MO budgeting methodology).

- *Assistance Unit (AU)* - An assistance unit is a group of individuals for whom AFDC-MO is requested or is a group of individuals who are currently receiving AFDC-MO.

- *Dependent Child* - A child under the age of 18 who is deprived of parental support or care because of the unemployment of the principal wage earner if both parents are in the home or because one or both parents are absent from the home, or one or both parents are deceased or physically/mentally incapacitated.

or

A child that is a fulltime student in a secondary school or an equivalent level of technical/vocational school is reasonably expected to complete the course or graduate before age 19 or in the month he/she attains the age of 19.

- Grantee Relative -A person who receives AFCD-MO for children in his/her care and may be a relative other than a parent. A grantee relative may request inclusion or exclusion in the AU.

Composition of the AU

The assistance unit **must** include the following individuals:

- A dependent child, unless he/she is an only child who receives SSI.
- Technically eligible whole, half or adopted sibling of the dependent child.
- The technically eligible parent(s), including an incapacitated parent or an unemployed parent, living in the home with the dependent child.

The assistance unit may include a grantee relative who is within the specified degree of relationship if:

- They provide a home for the child
- Exercises primary responsibility for care and control of the child, and
- Request inclusion, and
- Is technically and financially eligible.

Joint Custody

A relative is considered to have care and control of child when he/she has the major responsibility for parental obligations of day-to-day care, support, supervision and guidance for the child. These responsibilities may be carried out either alone or with another person living in the home. When the child lives with the relative, it is presumed that the relative has care and control of the child. However, there are certain situations when this may be questionable and the case manager must determine who has care and control of the child. The following are examples of instances when care and control must be established:

- joint custody cases;
- when the relative and the child live in different dwellings;
- when temporary absence is claimed; and
- when a relative who is not the parent receives Families First benefits for the
- child and a parent returns to the home.

The decision as to if the relative has care and control of a child is made on a case by case basis. The case manager/supervisor must evaluate the facts in each particular situation and use their best judgment. If the facts establish that the relative has care and control, then the child is considered to be living with that relative. See Procedures in this section for a guide in determining care and control.

EXCEPTIONS: When there is a situation of **joint custody**, the case manager must look at each situation on a case by case basis. If the child lives with both parents, then deprivation must exist based on incapacity or unemployed parent policy; unless the child lives with each parent for extended periods. In that case, the child may meet the deprivation by absence criteria and would be eligible to be included in the home of the parent with whom he/she resides at the time of application. When the child goes to live with the other parent, eligibility ceases to exist with the first parent.

Temporary Absence

A child may be temporarily absent from the home and continue to be eligible as a member of the budget group. Should this situation occur, it is the responsibility of the parent or caretaker relative to notify the eligibility worker of the circumstances surrounding the absence. The eligibility worker would then determine if eligibility should be continued.

Listed below are situations regarding absence from the home and how these situations affect eligibility:

- A child in Job Corps in Tennessee or another state may be eligible as a member of the budget group.
- A minor parent who is considered a dependent child may be eligible when temporarily absent for any purpose.
- Absence due to fulfilling military obligation is considered temporary absence; there, a parent who is away from home on military duty is considered part of the budget group unless there is abandonment of the family.
- A child temporarily out of the home and living in an institution may be eligible based on the type of facility in which he is living.
- Any family member who is residing elsewhere permanently cannot be considered temporarily absent.

Out-of-Home Living Arrangements

The chart below identifies under what circumstances an individual may remain as a member of the AG or apply as an individual.

TYPE OF FACILITY	TYPE OF CARE	MEDICAID STATUS
Non-Medicaid	Custodial	Individual
Residential Treatment and Group Homes	Psychiatric/Mental Health Services	With family if stay is 30 days or less Individual if stay if more than 30 days
Hospital not operated Primarily for the Mental Ill	Medical	With family

Nursing Home not operated primarily for the Mentally Ill	Medical	Individual
Education or Vocational	Education/Training	With family
Home for the Mentally Retarded	Education/Training	With family
Home for the Mental Retarded	Custodial	Individual
Maternity Home	Custodial	Individual
Juvenile Justice/Correctional	Custodial	Individual
Drug Treatment Facility	Medical	With family if stay is less than 30 days Individual if stay is more than 30 days

Additional Resource and Income Criteria Specific to AFDC-MO

In determining eligibility for AFDC-MO, in addition to regulations found in Chapter 5 (Resource Chapter) and Chapter 3 (Income Chapter) of this manual, Tennessee uses the following resource and income standards:

- Escrow profits for low-income entrepreneurs and Individual Development Account (IDA) up to $5,000 plus interest earned are excluded as countable resources.

- Lump sum payments are counted as income in the month received and a resource if retained.

- The first $4,600 of equity value in an automobile (if the automobile is not otherwise exempt) will be disregarded. Any excess equity value of the automobile or the equity value of any other vehicle(s) will be considered as a resource and applied to the $2,000 resource limit.

- Income methodology in effect prior to July 16, 1996 is raised effectively according to family size currently used under Families First; including any higher standard used for child-only cases, caretakers who are disabled over 60, and caretakers caring full-time for a disabled family member.

- Tennessee uses a less restrictive earned income deduction that is equal to $90 plus $30 and 1/3, and the current Families First earned income disregard ($250 for $2008), whichever is higher for applicants and recipients. The special earned income deduction is calculated in the example below.

Example:

Aid Group Size		3	
CNS		$1066	
	-	90	
	-	30	
		946	/ 3 = 315
	-	315	
		631	
	-	250	
		381	= Section 1931 additional earned income disregard

Technical Requirements

The following technical requirements are the same for FF cash payment, MA S (sibling income) and AFDC-MO 1931 categories:

- Age requirement
- Deprivation
- Specified degree of relationship
- Citizenship (refer to the Chapter in this Manual for further details)
- Residency (refer to the Chapter in this Manual for further details)
- Enumeration (refer to the Chapter in this Manual for further details)

AFDC-MO Deprivation

Policy Statement

To be eligible for AFDC-MO a child must be in need according to the AFDC-MO assistance standards and deprived of parental support and/or care. Deprivation is due continued absence of one or both parents, death of one or both parents, incapacity of one or both parents, or unemployment of one or both parents.

Absence

To determine that a child is deprived of parental support because of absence, the case manager must establish that at least one natural parent is absent from the home in which the child lives. As a condition of AFDC-MO eligibility, the remaining parent or caretaker relative must give required information about the absent parent and cooperate with the IV-D agency as necessary. If the absent parent has a separate living arrangement from the child for which AFDC-MO is requested,

absence can be considered to exist. Visits from the absent parent need not be based on a court order or other formal arrangement if the absence from the home is established as follows:

- Divorce of natural parents and only one or neither parent remains in the home with the child;
- Separation of parents;
- Desertion of one or both parents;
- Imprisonment of one or both parents;
- Institutionalization of one or both parents;

Death

Deprivation because of death of one or both parents must be documented on the appropriate ACCENT screens and in running record comments, CLRC. Verification of death may be obtained through any of the following sources:

- Death certificate
- Physician's report or statement
- Funeral home records;
- Cemetery records;
- Newspaper notices;
- The Division of Vital Records; or
- Statements from persons in a position to know

Incapacity

The assistance group for the AFDC-MO category meets the deprivation requirement when both parents live in the home with the child, if one of the parents is incapacitated. "Physical or mental incapacity" of a parent shall be deemed to exist when one parent has a physical or mental defect, illness, or impairment. The incapacity shall be supported by competent medical testimony and must be of such a debilitating nature as to reduce substantially or eliminate the parent's ability to support or care for the otherwise eligible child and be expected to last for a period of at least 30 days. In making the determination of ability to support, the agency shall take into account the limited employment opportunities of handicapped individuals.

Unemployed Parent Criteria for AFDC-MO Category

Tennessee has eliminated the 100-hour rule as criteria for an unemployed parent in a two-person household except in situations where the caretaker in an AFDC-MO family marries a non-recipient.

When deprivation is based on unemployed parent criteria, the principal wage earner must be unemployed for at least 30 days.

The Principal Wage Earner is defined as the parent (in a two-parent home) with the greater amount of earnings in a 24-month period including the month immediately preceding the application month. If both parents have the same amount of income, the Eligibility Counselor along with the family will designate the principal wage earner.

Under-employment is defined as a job paying minimum wage for less than 35 hours per week, which is offered by a private employer, self-employment, JTPS, or other work training programs under contract to, or in agreement with, the Department of Human Services. Under-employment of the principal wage earner is a basis for deprivation.

A Bona Fide Job Offer is defined as a job paying at least minimum wage for at least 35 hours per week, which is offered by a private employer, through self-employment, JTPA, or other work training programs under contract, or in agreement with, the Department of Human Services.

Good cause for failure to accept employment includes illness of a more serious nature than a common cold. Good cause may be granted for illness of an Aid Group parent or child, where the principal wage earner is the only available caregiver or:

- There is lack of transportation,
- The job is not within the documented physical or mental capability of the individual,
- The wage is less than the minimum wage,
- The job poses an unreasonable risk to health and safety of the person.

Establishing Incapacity

Eligibility for TennCare Medicaid benefits in some categories carries the technical requirement that an individual must be incapacitated. TennCare Medicaid benefits in the categories of AFDC-MO, including 1931 coverage, and MA S (individuals who would be eligible for Families First except for sibling income) requires that there be deprivation of parental support. One form of deprivation is the physical or mental incapacity of one of the parents.

This section contains the procedures to use in determining incapacity.

Incapacity exists if the mental or physical defect, illness, or impairment reduces substantially the parent's ability either to provide financial support for the child or to provide for the child's day-to-day physical care or guidance. Therefore, "incapacity" exists in either of the following circumstances:

- If the defect, illness, or impairment eliminates or substantially reduces the parent's ability to work, regardless of whether the person retains the ability to perform other parental functions. Examples include cases where there has been a significant reduction in a parent's work-relevant physical or mental capacities, or in earnings (either because of a reduction in hours worked or rate of pay) due to the defect, illness or impairment; or

- If the person's capacity to work is not reduced, but the defect, illness or impairment substantially reduces his or her ability to provide day-to–day physical care or guidance for the child.

- If the parent is temporarily hospitalized.

- If the parent is confined to a nursing home, institution for the mentally ill or retarded, or other long-term medical facility, base deprivation on continuous absence rather than incapacity.

Procedures for Substantiating Incapacity

There are several methods of determining incapacity. The following determinations may be accepted:

- Social security Administration (for Social Security benefits or Supplemental Security Income [SSI])

- U.S. Railroad Retirement Board

- Veteran's Administration (VA) for 100% disability

- Bureau of TennCare's Preadmission Evaluation (PAE) approval for an individual in long-term care

- DHS determination of incapacity

Deceased individuals are considered incapacitated without a formal determination by the Medical Evaluation Unit (MEU).

If a determination by SSA, RRB, or VA is not available, the DHS caseworker must assist the client in securing medical or mental health evidence to submit to the Medical Evaluation Unit (MEU) for an incapacity determination. The decision of the MEU is binding but may be appealed by the client.

Receipt of Social Security benefits or SSI benefits

Individuals receiving Social Security benefits based on their blindness or disability are considered to meet the incapacity criteria for TennCare Medicaid purposes. Verify that the individual receives Social Security and the basis of the entitlement (i.e. disability) using the following evidence:

- SSA award letter

- State On-Line Query (SOLQ)

- Information electronically sent to the data base by SSA or Bendex report if the individual:

    - is under age 62 and the SSA claim number suffix is "A", OR
    - is the disabled surviving (or disabled surviving divorced) spouse age 50-59 and whose SSA claim number suffix begin with "W", OR
    - is over 18 and has a SSA claim number suffix of "C".

- If the individual's Social Security benefits are terminated for any reason (except death), immediately take steps to establish incapacity through the MEU process. The TennCare Medicaid case may remain open during the period required to establish the client's satisfaction of the requirement. Close the case if the MEU determines the client is not incapacitated.

Use the following methods to establish current receipt of **SSI benefits** based on disability except for those with Current Pay Status code of S21. These individuals' eligibility is based on a presumption of their disability, and this does not satisfy the incapacity requirement for deprivation. The following establishes receipt of SSI based on disability:

- Electronic information sent to the data base by SSI and SOLQ
- "Rec type codes" of BI, BS, DI, DS, DC
- "Payment status codes" of C01, E01
- SDX on Clearinghouse

Receipt of Railroad Retirement Board Benefits (RRB)

Individuals receiving "Period of Disability" benefits from the U.S. Railroad Retirement Board are considered to be permanently and totally disabled and meet the incapacity requirement for TennCare Medicaid program purposes. "Occupational Disability" benefits are paid by the RRB and do NOT qualify the individual as incapacitated or disabled. Termination of benefits requires that DHS determine incapacity as set out above.

Verify RRB "Period of Disability" payments in one of these ways:

- Review the RRB Award Letter
- Secure written verification from the RRB substantiating benefit type
- Electronic information sent to the data base from RRD
- SOLQ

Receipt of VA Disability Benefits

Individuals receiving VA based on 100% disability are considered as incapacitated for the family and children's categories. Termination of benefits requires that DHS determine incapacity as set out above. Verify the benefits as follows:

- View the benefit notice

- Contact the local VA representative
- Contact the VA Regional Office. The request must contain the veteran's "C" or "CGS" number.

Established by Preadmission Evaluation for LTCF

Individuals approved for intermediate or skilled levels of nursing care by the Bureau of TennCare are considered incapacitated for TennCare Medicaid purposes. Initial PAE approvals may be sent by the LTCF to DHS by:

- Notation in the upper left corner of the Form 2350 advising of the individual's admission to the LTCF;
- A copy of the approved PAE form, or
- Other written verification of PAE approval.

If the PAE is denied, immediately take steps to establish the individual's incapacity through the MEU as appropriate.

Determination of Incapacity by MEU

If the parent does not receive any of the above mentioned benefits, the DHS caseworker must interview the individual and collect and record the data on the appropriate ACCENT screens.

Before sending the Medical Packet to the MEU

- Address and complete all technical eligibility issues at the local office;
- Ensure that the Families First case is in "interruption" status for time limits and for work requirements;
- Complete companion cases that can be completed (FS expedited, for example); and
- Submit the Incapacity packet to the MEU within one day of completion of all of the above.

Sending the Medical Packet to the MEU

All technical eligibility issues need to be addressed and completed in the local DHS office before sending the medical packet to the Medical Evaluation Unit for an incapacity decision. When technical and financial eligibility is established and an incapacity decision is required, the county caseworker will need to:

- Submit copies of the completed MEU (ACCENT) medical-social information screens;

- Have the applicant sign and date ten (10) HIPAA Authorization for Release of Information forms;

- Give the applicant a copy of the HIPAA privacy notice;

- Complete the MEU Information Checklist

- Ask applicant if he/she has any seizure or chest pain complaints

    - If yes, complete the following questionnaire(s), if appropriate,
        - SEIZURE QUESTIONAIRE
        - CHEST PAIN QUESTIONAIRE

In addition, any extenuating or pertinent information must be documented on ACCENT running record comments, CLRC.

The caseworker will mail all of the above information to the following address:

Medical Evaluation Unit
Tennessee Department of Human Services
400 Deaderick Street
Nashville, Tennessee 37248-7300

ACCENT Screens to be Completed

The caseworker is responsible for compiling the MEU packet by completing the following ACCENT screens:

- **AEIIM** - Complete this screen by entering "Y" under the "Aged/Incap" question starts the Incapacity screens.

- **AEIDP** - Complete this screen with the appropriate information.

  All MEU (ACCENT) medical-social information screens must be completed in their entirety by the caseworker. The MEU (ACCENT) medical-social information screens provide vital medical/mental health and social information that is used by the MEU, in conjunction with medical reports and records, to determine whether or not incapacity exists.

  Specific details are required on the MEU (ACCENT) medical-social information screens:

- **AEMII** – (Identification Data):

  Must have the following documented:

- County number
- Case number
- Category
- Sequence number
- Recipient ID #
- Enter personal information regarding the applicant's:
- Applicant's first name, middle initial and last name
- Social Security Number
- Age
- Height
- Weight
- Recipient number
- Physical address
- City, state and zip code
- Contact phone number (indicate if home phone or cell phone)
- Place of interview: DHS office? Or Phone interview?
- Educational level
    - Last grade completed
    - Age entered school
    - Age left school
    - GED degree YES or NO
    - Special Education degree YES or NO
    - College degree YES or NO
- Speaks English YES or NO
- Can read YES or NO
- Can write YES or NO

- **AEMIG** – (General Information) -Enter information regarding the applicant's:

    - Presently employed YES or NO
    - Current monthly salary
    - Hours worked per day
    - Days worked per week
    - Current Job title
    - Reason for leaving current or last job
    - Date last worked
    - Current living arrangement
        - Lives alone YES or NO
        - Lives with immediate family and/or friends YES or NO
        - List names of spouse, children, dependents, etc. currently living with applicant
    - SSA/SSI benefit status
        - Has applied for SSA/SSI disability benefits YES or NO
        - Date applied
        - Is case pending YES or NO

  - Is case in appeal status YES or NO
  - Has received a final decision YES or NO
- Received any Vocational rehabilitation services
  - Within the past 12 months YES or NO
  - Give date/year(s) that applicant received VR services and/or training

- **AEMIA** – (Additional Information) - Enter information regarding the applicant's:

  - Apparel, grooming and over all appearance
  - State any obvious evidence of applicant's physical and/or mental impairment(s)
  - Attitude and degree of cooperation with the application process
  - Does the applicant use any assistive device for walking YES or NO
  - Name type of device such as a: Leg/foot boot? Cane? Walker? Wheelchair?
  - Complains of a hearing problem YES or NO
    - Needs hearing aides YES or NO
    - Date/year hearing aides issued or last updated?
  - Complains of vision problems YES or NO
    - Glasses needed YES or NO
    - Date/year glasses were issued or last updated
  - Write any "other pertinent information" (not covered elsewhere)

> ***NOTE:*** If a face-to-face interview cannot be conducted with the applicant, please provide an explanation of why the applicant was not interviewed under "other pertinent information."

- ***AEMIM*** – (Medical Information) - Enter information regarding the applicant's statement of his/her:

  - Disabling/incapacitating impairment(s)
  - Describe how the impairment(s) limit his/her daily activities
  - Describe how the impairment(s) prevent employment activities
  - List all current medications taken by applicant
  - Does applicant medically REQUIRE any attendant care? YES or NO
  - If YES, is this care provided by Family? Or Professional Services?
  - List name and date/year (within the past 5 years) of all
    - Major illnesses that you were hospitalized
    - Major surgeries that that you were hospitalized or one day outpatient surgery

- ***AEMIT*** – (Medical Treatment) - Have you

- Been sent for any special examination(s) in the past 12 months by:
    - SSA/DDS, YES or NO
    - Vocational rehabilitation, YES or NO
- Received any medical/mental treatment(s) in the past 2 years? YES or NO
- Ever received psychological/psychiatric treatment(s)? YES or NO

Must have list of:

- Name(s), complete address and phone number(s) of ALL medical/mental providers who have treated the applicant within the last 2 years
- Name(s) & address of all Emergency Room (ER) visits to any hospital in the past 12 months
- Name(s) & address of all Hospitalizations in the past 12 months
- Name(s) & address of all psychological/psychiatric/mental health providers in the past 5 years
- Date(s)/year(s) of treatment

The MEU will use this information to request medical/psychological/psychiatric reports from the identified medical/mental health providers, in compliance with HIPAA regulations.

- ***AEMIV*** – (Vocational Information) - Enter information concerning the applicant's work experience history for the past 15 years:

    - Beginning with the most recent job
    - Use a new (AEMIV) vocational Information screen for EACH job in the last 15 years
    - Must include the following data:
        - Job Title
        - Type of business
        - Date(s)/Years(s) worked: (from) & (to)
        - Hours worked per week: 20hrs/week? 40hrs/week?
        - Weekly pay
        - Use of any machines, tools and/or equipment? YES or NO
        - Writing and/or typing of complex reports. Etc.? YES or NO
        - Job requires use of technical knowledge and/or skills? YES or NO
        - Any supervisory responsibilities in job? YES or NO
        - Basic duties of the job
    - Number of hours spent daily doing the following activities at each job:
        - Walking (per 8 hour work day) 2? 4? 6? 8?
        - Standing (per 8 hour work day) 2? 4? 6? 8?
        - Sitting (per 8 hour work day) 2? 4? 6? 8?
        - Bending (per 8 hour work day)

- Never? Occasionally? Frequently? Constantly?
- Lifting/carrying (What and how far)
- Heaviest weight lifted: 10? 20? 50? 100? Over 100?
- Frequently carried: 10? 20? 50? Over 50?

Acceptable Medical/Mental Health Information Sources

Evidence from acceptable medical/mental health sources is needed to establish whether an individual has a medically determinable impairment. Acceptable medical and mental health information sources are:

- Licensed physicians (medical or osteopathic doctors), nurse practitioners, and physicians' assistants.
- Licensed or certified psychologists: ED.D, PH.D, PSY.D, mental health centers, and psychological examiners.
- Hospital medical records
- Licensed optometrists for the measurement of visual acuity and visual fields. A report may also be needed from a physician to determine other aspects of eye diseases;
- Licensed podiatrists for purposes of establishing impairments of the foot, or foot and ankle, depending on whether the state in which the podiatrist practices permits the practice of podiatry on the foot only, or the foot and ankle, and
- Qualified speech-language pathologists (SLPs) for purposes of establishing speech or language impairments only. For this source, "qualified" means that the SLP must be licensed by the state professional licensing agency, or be fully certified by the state education agency in the state in which he/she practices, or holds a Certificate of Clinical Competence from the American-Speech-Language-Hearing Association.

In addition to evidence from the acceptable medical/mental health sources listed, evidence from other sources may also be used to show the severity of an individual's impairment(s) and how it affects his/her ability to work. Other sources include, but are not limited to:

- Naturopaths
- Chiropractors
- Audiologists
- Physical therapists.

Procedures for scheduling MEU examinations and Travel Reimbursement

MEU may authorization a physical and/or psychological exam(s), if deemed appropriate. The MEU may authorize additional medical/mental health appointments as deemed necessary to make an accurate incapacity determination. Applicants may be reimbursed for travel needed to keep medical/mental health appointments.

The MEU will notify the applicant that a physical and/or psychological examination(s) is needed and ask if he/she is willing to go for the exam. If yes, the MEU will call the doctor's and/or psychologist's office, sets up the appointment date and time, and notifies the applicant of the date

and time. The MEU will complete the Travel Reimbursement form (if appropriate) and mail it to the applicant.

It is the applicant's responsibility to make necessary transportation arrangements for the scheduled exam(s). In urban counties where local bus service is available countywide, travel costs will not be reimbursed. Of course, this policy does not apply if inter-county travel is required to keep the medical/mental health appointment. Reimbursement will be made only if the appointment is kept. Reimbursement authorizations must be made prior to the appointment date, not after the fact.

If the physician needs any tests completed, he/she should call the MEU in the DHS state office Medicaid/TennCare Policy unit. In some instances psychological examiners travel to the local DHS county office to do these exams. If so, we may pay them a travel fee of $25.00.

If the client is a no-show for the exam and does not notify MEU of the reason, the designated MEU staff member should try to contact the client for an explanation. If an acceptable reason is given, the appointment is rescheduled. However, if the client does not have an acceptable reason or does not wish to reschedule, this fact will be noted in the applicant's file and MEU will make a decision with current evidence in the file.

If travel costs need to be reimbursed, an "Authorization for Travel Reimbursement Voucher" (HS-2691) is completed. The completed form designates the appropriate amount based on Roundtrip "point-to-point" mileage. "Point-to-point" mileage is determined by using Tennessee's "Official Highway Mileage Guide" doubling the amount to determine the Roundtrip mileage. This website can be used to determine "point to point" Mileage also: www.mapquest.com.

NOTE: Standard mileage reimbursement rate is **$.42 per mile effective 1/1/2006** as authorized by the Department of Finance and Administrative. http://www.intranet.state.tn.us/finance/

- The customer's Social Security number and current address must be completed on each Travel Authorization.
- Every customer needing travel reimbursement must sign a "MEU Customer Acceptance Authorization" form (HS-2690). This form explains the conditions upon which travel reimbursement can be made.
- Designated MEU staff will mail a letter to the applicant with the following data:

    - The appointment date and time of the exam(s)
    - A completed "MEU Authorization for Travel Reimbursement Voucher" (HS-2691) (one for each trip when more than one exam is requested)
    - "MEU Customer Acceptance Authorization" form (HS-2690)
    - Including a Business Reply Envelope.
    - Applicant is required to sign both forms and return them per US mail to MEU using the MEU/TDHS business reply envelope provided.

The two (or more) forms must be signed, dated and returned to MEU. The returned forms should be kept with the Incapacity medical file, until MEU can verify that the applicant kept the examination appointment(s).

On receipt of the Physical/Psychological Exam(s) report form(s), the designated MEU staff will authorize the Travel Reimbursement voucher and forward to DHS Fiscal services for payment. This process takes about 6 to 8 weeks; then, the applicant should receive a personal check from the State of Tennessee for the deemed appropriate amount per Tennessee law.

NOTE: The MEU Authorization for Travel Reimbursement Voucher (HS-2691) will be a three-part form so that the applicant can retain a copy. The form also explains that payment should be made within six to eight weeks following the date of travel.

Incapacity Determination by the Medical Evaluation Unit:

The MEU staff will make the incapacity decision based on the "Sequential Evaluation process." An MEU approval of incapacity must be at least 30 days, but no longer than 12 months. All active Incapacity cases must be reviewed yearly, both technically and financially by the local DHS caseworker. If determined eligible, the caseworker will compile the MEU packet by completing the following ACCENT screens.

- ***AEIIM*** - Complete this screen by entering "Y" under the "Aged/Incap" question starts the Incapacity screens.

- ***AEIDP*** - Complete this screen with the appropriate information.

All MEU (ACCENT) medical-social information screens MUST BE COMPLETED IN THEIR ENTIRETY by the caseworker. The MEU (ACCENT) medical-social information screens provide vital medical/mental health and social information that is used by the MEU, in conjunction with medical reports and records, to determine whether or not incapacity exists.

Guidelines for MEU Case Development

The MEU will DENY the Incapacity case, if applicant's gross monthly income is $900 or greater. Federal regulation defines this as being "gainfully employed." This decision cannot be made in the local DHS County office.

SGA/SSA WEBSITE reference is: http://policy.ssa.gov/poms.nsf/lnx/0410501015

Designated MEU Staff will:

- Enter the MEU Incapacity case into the MEU Tracking system

- Review the MEU packet that the local DHS caseworker mails to MEU for completion of these required documents:

    - MEU Information Checklist
    - ACCENT screens
    - HIPAA forms

- Seizure and/or Chest pain questionnaires, if appropriate

- Will contact the DHS caseworker, if necessary MEU documents are incomplete and request completion, as required

- Will write letters to all medical/mental providers, listed by the applicant as current treatment sources, requesting copies of their medical transcripts of all office visits in the past 12 to 24 months from date of application.

- Will also request objective evidence from provider(s) in the form of "typed reports" of the following data:

  - X-rays, MRI, EKG, PFS, NCS, lab work, CT scan, sleep studies, cardiac catherizations, UDS, Drug levels related to Seizure medications, etc.

- Will request a copy of hospitalization data in the past 12 months of the following:

  - Admission and Discharge summaries notes
  - Operative reports
  - Final pathology reports
  - Consultant reports
  - Psychiatric and/or psychological evaluations
  - Physical therapy notes
  - ER visits/reports
  - Hospital clinic treatment notes

- Will review all data received from medical/mental providers to assure that it is:

  - Legible
  - Relevant
  - Supportive and objective evidence that verifies the diagnosis/diagnoses

- Will contact SSA/DDS and/or Vocational Rehabilitation to obtain any relevant medical/mental data

- If indicated, will contact the applicant's pharmacy for a listing of all medications prescribed and filled in the past 12 months

- Will make a decision regarding Incapacity based on the "Sequential Evaluation Process'

Requesting Medical/Mental Health Information from Providers

When requesting medical/mental health information from providers, the designated MEU staff will send the following forms:

- MEU Authorization for Claim and Payment form (HS-0272)

- Marking the box: Medical/Mental Health Transcripts $20.00.

- MEU provider cover letter
- HIPAA Authorization for Release of Information form (HS-2557)

NOTE: MEU pays for Medical/ Mental Transcripts from all doctors, psychologist, hospitals, mental health centers, etc. that are related to verifying the applicant's claim for "incapacity."

Per Tennessee law (T.C.A. 63-2-102) passed in 1997 changed this fee to the following:

- $20 for records forty pages or less length
- 25¢ per page for each page copied after the first 40 pages
- Actual mailing cost if applicable

NOTE: We do NOT pay for copies of medical/mental health transcripts from other Federal/State agencies such as: VR, DDS, VA, Health Dept., state Mental Health Institutes, etc.

Collecting medical information for Incapacitated Individuals

The following is a list of questions that can act as a guide in obtaining medical/mental health information so that an incapacity determination can be made:

- If a claim of incapacity is based on recent hospitalization, do you have the hospital admission and discharge summaries?
- Have copies of other pertinent medical/mental health information, such as treating physician(s) treatment notes, information submitted to SSA/SSI for disability determination, mental health providers, other hospital records, etc. been obtained?
- Do all medical/mental reports speak to the applicant's primary complaint (the basis for his/her claim to be incapacitated) and most, if not all, of his/her other significant symptoms?
- Is a diagnosis and prognosis given?
- Does the medical/mental health information appear to support the diagnosis?

The ACCENT screens must be completed and submitted in their entirety. However, the following questions should be answered to ensure that the caseworker obtains and submits the needed information to the appropriate individuals for incapacity determination.

- Did the caseworker interview the incapacitated person? If not, why? Who was interviewed? What is the relationship of the interviewee to the incapacitated person?
- Did the caseworker properly document the required information such as name, SSN, grade level attained, birth date, etc.?
- Was complete vocational/employment history obtained specifying types of work activities?
    - Was information available and obtained about all of the applicant's complaints?

Once the adequacy of the medical-social information is assessed and any available and necessary additional information is obtained, the DHS caseworker mails the Incapacity packet to MEU for case development and review.

Collecting medical information for Incapacitated Individuals

The Sequential Evaluation process:

Step 1: Is the parent/applicant employed full time at his/her usual job?

- If yes, stop… Not Incapacitated.
- If no, go on.

Step 2: Does medical/mental evidence establish an impairment that substantially reduces or eliminates the parent's/applicant's ability to support and/or care for his/her children?

- If yes, go on. List Impairment(s) found.
- Is the impairment expected to last at least 30 days?
- If yes, stop… Incapacitated.
- If no, go on.

Step 3: List the following: applicant's age, education and past work experience. Based on parent's/applicant's age, education, usual work experience, physical/mental condition, and taking into account the limited employment opportunities for the handicapped, is his/her ability to support his/her family and/or care for his/her children substantially reduced?

- If yes, go on
- If no, stop… Not Incapacitated
- List work parent/applicant can perform
- Is the condition expected to last at least 30 days?
- If yes, stop… Incapacitated
- If no, stop… Not Incapacitated

MEU staff members decide whether the medical/mental health evidence substantiates that a physical/mental defect, illness, or impairment exists and the period of time the condition is likely to last. The medical/mental health and medical-social information is then evaluated together, and the designated MEU staff member decides whether the existing physical/mental condition substantially reduces or eliminates this person's ability to provide support or care for his/her child.

Questions which the designated MEU staff member must answer affirmatively in order to approve the incapacity include the following:

- Has the physician or mental health provider given a diagnosis of a physical/mental condition?

- Does the medical/mental health information reported appear to support the diagnosis?
- Has the physician given a prognosis and recommendation?
- Based on the diagnosis and prognosis, does it appear that the incapacity will last 30 days or more from the month of application?
- Does the diagnosed condition substantially reduce or eliminate the person's ability to work in his/her usual occupation or any other occupation, which is within his/her physical/mental competence; or does the diagnosed condition substantially reduce or eliminate the person's ability to care for children (which may be his/her usual occupation)?

Consideration must be given to the limited employment opportunities for handicapped individuals. A high unemployment rate is not decisive in this matter. The decision must be whether this person's physical/mental condition substantially reduces or eliminates his/her ability to provide support or care for his/her child and taking into account general economy for handicapped people. The age and nurturing needs of children being cared for must be considered in determining whether or not the diagnosed condition meets incapacity requirements.

Expedited Referrals to the MEU

The DHS caseworker should note on the MEU Information Checklist "Medically Necessary EXPEDITED STATUS" for the following:

- Metastatic cancer must have hospital admission and discharge notes, pathology (biopsy) report, operative notes, etc.
- Other malignant diseases such as, Hodgkin's disease, lymphoma, leukemia, melanoma, and sarcoma, etc., requesting the same medical data as listed above.
- AIDS/HIV+ must have current medical data verifying acute and chronic symptoms such as diarrhea, weight loss, recurrent infections, fatigue, etc.
- Chemotherapy with current medical data to verify severe side effects such as nausea, vomiting, diarrhea, weight loss, recurrent infections, etc.
- Severe head injury must have hospital data.
- Severe spinal cord injury, quadriplegic, paraplegic with hospital data.
- Severe renal (kidney) failure and/or hemodialysis with hospital records.
- Severe coronary artery disease with hospital data verifying heart attack, myocardial infarction, strokes.
- Severe emphysema/COPD (chronic obstructive pulmonary disease) with hospital data.
- Acute (not chronic) leukemia must have pathology report to verify diagnosis.
- Immediate threats of suicide must have current medical data from the hospital or mental health provider to verify.
- Active TB

Evaluation of the Treating Physician's Findings and Recommendations

The designated MEU staff may place considerable reliance on the treating/examining physician's and/or mental health provider's findings/recommendations as to whether or not a physical/mental defects, illness, or impairment exists. The physician's findings should include:

- A diagnosis and clinical/medical/mental health evidence to support the diagnosis; and
- A prognosis that appears to be reasonable in light of the diagnosis.

A "prescription pad" statement or a letter from a physician without supporting medical evidence is not acceptable.

The decision that incapacity exists according to definition is a programmatic one. The decision must be made based on the medical and/or mental health findings/recommendations as they apply to a particular person and his/her ability to continue his/her current employment/care activities. The MEU decision is binding on the DHS county office.

Reconsideration of Incapacity Decisions

If an individual disagrees with the MEU decision and has additional/new medical information he/she wishes to submit, he/she may request reconsideration of the decision. If the individual does not have additional medical or mental health information or does not want to request reconsideration, he/she should be helped to file an appeal. To assure that an individual has the opportunity to file an appeal within 90 days of the action to deny or terminate, an appeal request should be filed at the same time the request for reconsideration is made.

If the individual requests reconsideration of an MEU decision, the DHS caseworker needs to explain the reconsideration process to the applicant. The caseworker will complete the following:

- Submit copies of the updated and completed MEU (ACCENT) medical-social information screens
- Have applicant sign and date 10 HIPAA Authorization for release of information forms
- Give applicant a copy of the HIPAA privacy notice
- Will complete the MEU Information Checklist
- Will ask applicant if he/she has any seizure or chest pain complaints
    - If yes, will complete the following questionnaire(s), if appropriate:
        - SEIZURE QUESTIONAIRE
        - CHEST PAIN QUESTIONAIRE

NOTE: The caseworker will mail all of the above items to the Medical Evaluation Unit no later than the 5th day from the applicant's Reconsideration date.

MEU mailing address is:

Medical Evaluation Unit
Tennessee Department of Human Services
400 Deadrick Street
Nashville, TN 37248-7300

- Secure the Request for Delay in Fair Hearing to postpone the appeal until the MEU can re-evaluate the case; and
- Request for Delay in Fair Hearing and a memorandum explaining that the individual has requested reconsideration and has filed an appeal.

  Upon re-evaluation of all information at reconsideration, the MEU may approve or deny incapacity, or may request one or more specialist examinations or other information. If the MEU approves incapacity, give the individual an opportunity to withdraw his/her appeal request using the Withdrawal of Complaint.

  If the MEU again denies incapacity, the DHS caseworker should complete the appeal process. Upon notification from the MEU of the decision, the DHS caseworker should promptly notify the individual and his/her legal representative, if any, and take action as shown above for approvals or denials.

Incapacity Determination by Appeal

When an incapacity decision has been appealed, implement the final order as approved by the Director of Appeals.

Review of Active Incapacity Cases

Incapacity must be re-evaluated at the end of the approval period following procedures described for applications. If the individual states that he/she is no longer incapacitated and asks for case closure, medical re-evaluation is unnecessary. The DHS caseworker is responsible to contact the applicant 30 days prior to the end of the MEU approval period. Eligibility continues until a decision on continued incapacity is made. The DHS caseworker needs to re-evaluate all eligibility criteria and determine if an Incapacity decision is still needed.

If Incapacity is still needed; then, the DHS caseworker will complete the following:

- UPDATE and completed MEU (ACCENT) medical-social information screens and make copies to send to MEU
- Have applicant sign and date 10 HIPAA Authorization for release of information forms
- Give applicant a copy of the HIPAA privacy notice
- Will complete the MEU Information Checklist
- Will ask applicant if he/she has any seizure or chest pain complaints
- If yes, will complete the following questionnaire(s), if appropriate:
  - SEIZURE QUESTIONAIRE
  - CHEST PAIN QUESTIONAIRE

The DHS caseworker will mail all of the above items to the Medical Evaluation Unit no later than 7th day from the beginning of the Active case re-review process.

MEU mailing address is:

Medical Evaluation Unit
Tennessee Department of Human Services
400 Deadrick Street
Nashville, TN 37248-7300

In addition, any extenuating or pertinent information must be documented on ACCENT running record comments, CLRC.

MEU Release of Information Procedures

The Health Insurance and Portability Act, HIPAA, of 1996 was passed by Congress effective April 11, 2003. This comprehensive Federal regulation is aimed at protecting the confidentiality of our clients' medical records and health information. Primarily, the privacy rule sets standards which govern the use and disclosure of private health information (PHI), gives clients new privacy rights regarding access to and use of their medical records, and imposes responsibilities on health care providers (doctors, nurses, hospitals, mental health agencies, etc.) and Federal and State agencies that obtain PHI. (Please refer to the General Administrative Procedures Chapter of this Manual for detailed information on HIPAA.)

The following HIPAA forms can be found on the DHS Intranet and the DHS GroupWise Default Library:

- HIPAA Authorization for Release of Information (English) (HS-2557)
- HIPAA Authorization for Release of Information (Spanish) (HS-2811)
- HIPAA DHS Privacy Notice (English)
- HIPAA DHS Privacy Notice (Spanish)
- HIPAA Authorization for Release to 3rd Party (English) (HS-2898)
- HIPAA Authorization for Release to 3rd Party (Spanish) (HS-2899)

Protected health information includes:

- Name
- Address
- Social security number
- Date of birth
- Fingerprints
- Photograph
- Names of relatives
- Employer
- Telephone number
- Medical record number
- Health plan number
- Enrollment status/program eligibility data
- Certification/license number

This law requires DHS to maintain the privacy of our applicants and recipients by not releasing their individually identifiable health information and enrollment status to anyone except the applicant/client, unless they provide us written permission.

The MEU Incapacity Unit or the local DHS office can make copies of medical/mental health data as long as there is a signed and current (within the last 60 days) HIPAA Release of Information

form from the client. However, these copies should not be given directly to the client. They should be mailed from the MEU Incapacity Unit or the local DHS office to the client's lawyer, doctor, or agency (such as DDS) that has requested the information in writing and has sent a signed release form with the proper address to which the information is to be mailed.

It is important to keep a copy of the request letter and signed release in the DHS and/or the MEU case file to serve as evidence regarding confidentiality issues.

Incapacity Determination (MEU) Forms

These MEU forms are in the GroupWise Default Library

- MEU Information Checklist
- MEU Seizure Questionnaire
- MEU Chest Pain Questionnaire

Other MEU Issues

Once MEU has made a decision, the entire Incapacity Medical Packet (including the MEU decision sheet, medical/mental records) will be returned per US mail to the local DHS office for archiving.

-
- If the Incapacity case was DENIED by MEU, a reconsideration may be requested by the applicant, but MUST include UPDATED names & addresses of Providers whom they have seen since the last MEU case decision. If NO UPDATED treatment data is available, proceed with the appeal process.
-
- If MEU approved the incapacity 30 days PRIOR to the end of the approval period, the caseworker will:

    - Complete a new Medical/Social (ACCENT) screens with updated information
    - Complete a new MEU Information Checklist form
    - Include 10 new HIPAA release forms (signed & dated)
    - Give the applicant a new HIPAA Privacy notice
    - Mail the "entire" Incapacity Medical Packet (including all past records) to MEU

Eligibility Criteria

The eligibility criteria for the Families First cash assistance program and the AFDC program prior to the implementation of Families First in July 1996 are the same except for the differences listed below. These differences would apply to both the MA S and the AFDC-MO 1931 coverage categories.

Assistance Group Composition.

Family cap and Marriage During Receipt of Assistance policies do not apply. If the caretaker marries the legal father of the children, the aid group is no longer eligible, and the aid group would NOT be eligible for Transitional Medicaid. Drug felony and Fleeing Felon policy does not apply.

Personal Responsibility Plan.

There is no PRP requirement.

Non-cooperation with child support.

Only the caretaker is ineligible for non-cooperation with child support. If the caretaker refuses to cooperate in naming the father or to assign medical support, the entire aid group is ineligible. See chapter on Child Support Cooperation.

Non-compliance with work requirements.

There is no work requirement.

Time limits.

There are no time limits for duration of assistance.

Voluntary quit.

There is no voluntary quit penalty.

Non-recurring lump sum payments.

For the AFDC-MO 1931 coverage group, count as income in the month received and a resource if retained.

Treatment of Income – AFDC-MO and Sibling Income

***I**ndividuals whose Income Must be Considered*

- All Assistance group members

  Consider the countable gross income, earned and unearned, of all assistance group members and their responsible relatives in the home plus the deemed income of an in-home stepparent and parent of a minor parent, as available. Test the gross amount against the amount equal to 185% of the appropriate consolidated need standard (i.e., gross income standard). This procedure screens in families with amounts less than the standard and

screens out those with greater amounts. No income of parents and spouses (i.e., responsible relatives) is diverted to their ineligible dependent(s) living in the home except in the deeming budgets of stepparents and parents of a minor parent.

- Spouses

  Consider the income belonging to one or both members of a married couple as available to each other as long as they are living together.

  Consider the income of a minor's spouse living in the home with the minor as available in its entirety to the minor when the minor is included in an assistance group.

  The income of a spouse who is an SSI recipient is disregarded in determining the other spouse's eligibility and the amount of assistance.

  If the couple presents themselves as married, they are to be considered married. If they later claim to not be married, the burden of proof of their unmarried status will be upon the couple.

- Income of Children:

  - Do not count the income of a technically ineligible child (i.e., ineligible due to age, deprivation, and citizenship).

  - Count the income of a child, who is a minor parent and is sanctioned for failure to cooperate with school attendance requirements or the income of a child sanctioned for enumeration.

  - Do not count a child SSI recipient's income.

  - Do not count the income designated or legally "earmarked" for a child applicant/recipient, but not actually received, in determining eligibility. Although the money will not be counted in the AG, the caretaker must apply to have the money made available to the child.

- Parents

  Parents are responsible for the support of their dependent children until the children become age 18 (or age 19 if applicable). Parents living in the home with their children must be included in the assistance group and their total income counted as available in its entirety, unless the parent is an SSI recipient. Count the income of parents excluded from the assistance group because of a disqualification technical ineligibility such as citizenship or enumeration penalty as available to the assistance group.

  Parent(s) of a minor parent who applies for or receives Medicaid Only for her/his own children are not pulled into the minor parent's AG. However, if the minor parent's parent

receives Medicaid only benefits for the minor's siblings, the minor must be included in her/his parent's AG.

- Stepparents and Parents of Minor Parents

  Deem income as available to assistance group members from persons listed below under the given circumstances:

  - A stepparent living in the home with stepchildren for whom assistance is requested.

  - Do not deem income from a stepparent or a parent who is an SSI recipient.

  Determine the amount of income to consider available to the stepchildren/minor parents as follows:

  - Determine gross monthly income;

  - From earned income only for fulltime or part-time employment, deduct the flat work expense amount of $150 for the MA S category, and for the AFDC-MO 1931 category, follow the instructions below in the Budgeting Methodology section;

  - Deduct the appropriate Consolidated Need Standard for the stepparent or parent and his legal dependents (for IRS tax purposes) living in the home who are not included in the aid group. (If the stepparent or parent's income is not taxable, use those individuals (s)he could claim under IRS rules.) NOTE: The natural/legal parent of the dependent child must be included in the aid group; her/his needs may not then be included again in the deeming budget.

  - Deduct amounts actually paid for alimony or child support to individuals not living in the home other than those covered in those mentioned above;

  - Show the remainder as income deemed to the stepchildren or minor parent, as appropriate.

- Applicant/Grantee Relative Other than Parents

  Count the income of the caretaker relative if the relative is included in the AG. The caretaker must be pregnant or under age 21. When the caretaker relative is included in the AG, all of the income of the relative's spouse is considered available to the AG.

CHART FOR INDIVIDUALS WHOSE INCOME IS CONSIDERED	
Individual	Special instruction
Dependent children in the home	The earned income of a dependent child who is in the budget group is excluded. The earned income of a minor parent is counted to determine eligibility for the minor parent's child, unless the minor parent is a full time student. **NOTE**: A child who is expected to graduate from high school by his/her 19th birthday may be included in the AG.
Parent(s) in the home	All income must be counted unless specifically excluded.
Parent absent due to military obligation	All income must be counted unless specifically excluded.
Caretaker relative other than the parent(s) of the children	Count income if the caretaker relative requests inclusion in the AG, unless income is specifically excluded.
Stepparent in home with a child(ren) in common	Count income of parent and stepparent, less disregards.
Stepparent in home, no child(ren) in common	Count stepparent's deemed income available to the AG.
Stepparent in home, no child(ren) in common, each have their own children	Treat each as a separate AG because there is no blood relationship.
Parents with no income, child receives SSI	Include the parent as a SSI caretaker.

Child Support Only

Child support received by the caretaker with no other income is budgeted using the following procedures:

- Subtract the $50 disregard from the gross amount of child support collected.

- If there is no other income, test the remainder of the child support against the GIS for the appropriate size family. Deny or close the case if the total gross income is over the GIS.
- If under the GIS, subtract the income from the Consolidated Need Standard (CNS). If net income is less than the CNS, the AG is eligible for AFDC-MO.
- If the net income is greater than the CNS, the AG is not eligible in the AFDC-MO category.

EXAMPLE: Caretaker and two children applied for AFDC-MO, caretaker receives $700 in child support and no other income.

GIS	$1782.00
Amount of child support received	700.00
Minus disregard	- 50.00
Total countable income	650.00
CNS	963.00

Child Support is less than the CNS ---- AG is eligible for AFDC-MO.

Child Support and Other Income

Child support along with other income is budgeted using the following procedures:

- Subtract the $50 disregard from the gross amount of child support collected.
- Add the remainder to the total monthly gross income.
- Test the new total against the gross income standard for the appropriate size family. If the total income is over the GIS close or deny.
- If less than the GIS, compare the total income to the CNS for the appropriate family size.
- If net income is less than the CNS, AG is eligible in the AFDC-MO category.
- If net income is greater than CNS close or deny case

Example: Caretaker and two children apply for AFDC-MO, caretaker receives $700 in child support and $1010 in unemployment benefits and no other income.

GIS	1782.00
Child Support Income	700.00
Minus Disregard	- 50.00
Countable Child Support	650.00
Unemployment Income	+ 1010.00
Total Countable Income	$1710
CNS	$963

Total net income is greater than the CNS, deny or close case.

NOTE: If case is closed due to an increase in child support, AG is eligible for extended Medicaid

Individuals Whose Income is NOT to be Considered

- SSI recipients (regardless of relationship)
- Ineligible relatives other than parents/stepparents that are not in the AG
- Unrelated AG members
- Individuals living outside the home except for a parent in the uniformed services and out-stationed.

Cash contributions from individuals living outside the home are to be counted if more than $30 per quarter per member.

Self Employment Income

Income which is received annually, and/or which is an integral part of annual income, will be totaled and prorated over 12 months, even if the income is received only once or over a period of time shorter than 12 months. Such income usually is derived from farming, but also may apply to other self-employment enterprises.

Annual Income

Income which is received annually, and/or which is an integral part of annual income, will be totaled and prorated over 12 months, even if the income is received only once over a period of time shorter than 12 months. Such income usually is derived from farming, but also may apply to other self-employment enterprises. Annual income will be prorated over 12 months even if a person has income from sources other than self-employment. Income received once annually will be prorated over 12 months beginning with the month the income is received. Income which represents annual income, but which is received periodically during a year will be totaled and averaged over 12 months. This average figure will be used to project future income (if all other factors remain relatively constant). If a self-employed person is under contract, the 12-month period begins the first month the person receives payment under the contract.

Income from Migrant Labor, Seasonal Work

Income which is received annually, and/or which is an integral part of annual income, will be totaled and prorated over 12 months, even if the income is received only once over a period of time shorter than 12 months. Such income usually is derived from farming, but also may apply to other self-employment enterprises. Annual income will be prorated over 12 months even if a person has income from sources other than self-employment. Income received once annually will be prorated over 12 months beginning with the month the income is received. Income which represents annual income, but which is received periodically during a year will be totaled and averaged over 12 months. This average figure will be used to project future income (if all other factors remain relatively constant). If a self-employed person is under contract, the 12-month period begins the first month the person receives payment under the contract.

Monthly Self-Employment Income

When self-employment income is received monthly, the average monthly income will be estimated based on past income and substantial changes in circumstances which have occurred, such as an increase or decrease in business.

Capital Gains Income

The proceeds from the sale of capital goods or equipment are calculated in the same manner as a capital gain for federal income tax purposes. Even if only 50% of the proceeds from the sale of capital goods or equipment is taxed for federal income tax purposes, the caseworker will count the full amount of the capital gain as income.

Costs of Producing Self-Employment Income

When a member of the AG receives income from self-employment, (s)he will be required to keep a record of expenses incurred in the production of this income.

- Expenses:
    - Identifiable costs of labor (salaries, employer's share of SS, insurance, etc.)
    - Stock, raw materials, seed and fertilizer, feed for livestock
    - Rent and cost of building maintenance
    - Business telephone costs
    - Costs of operating a motor vehicle when required in connection with the operation of the business
    - Interest paid to purchase income producing property
    - Insurance premiums and taxes paid on income producing property
    - Costs of feed for work stock
    - Costs of meals and equipment for children for whom day care is provided in the
    - A/R's home.
- Unallowable Deductions from Self-Employment Income
    - Payments on the principal of the purchase price of income producing real estate and capital assets, equipment machinery, and other durable goods;

- Net losses from previous periods;
- Federal, state, and local income taxes, money set aside for retirement purposes, and other work related personal expenses (such as transportation to and from work).
- These expenses are accounted for by the work expense allowance;
- Costs of producing home produce intended for family consumption;
- Family living expenses;
- Depreciation

Determining Monthly Self-Employment Income When Averaged

For the period of time over which self-employment is determined, add all gross self-employment income (including capital gains), exclude the costs of producing the self-employment income, and divide the self-employment income by the number of months over which the income will be averaged.

Determining Monthly Self-Employment Income When Anticipated

For the period of time over which self-employment is determined, add all gross self-employment income (including capital gains), exclude the costs of producing the self-employment income, and divide the self-employment income by the number of months over which the income will be averaged.

Assistance Groups with Boarders

AG/s that take in boarders or that operate commercial boarding houses are considered self-employed. Identifiable expenses are allowed as costs of doing business, as in any self-employment.

Determining Income for AG

The income from boarders (self-employment income) includes all direct payments to the household for room and meals, including contributions to the household's shelter expenses. Shelter expenses paid directly by boarders to someone outside of the household are not counted as income to the AG.

Cost of Doing Business

After determining the income received from the boarders, exclude that portion of the boarder payment which is a cost of doing business. The cost of doing business is equal to one of the following, provided that the amount allowed as the cost of doing business does not exceed the payment the household received from the boarder for lodging and meals:

- the cost of the Thrifty Food Plan (Food Stamp program) for a household size that is equal to the number of boarders; or

- the actual documented cost of providing room and meals if applicant claims actual costs exceeding the Thrifty Food Plan. If actual costs are used, the only separate and identifiable costs of providing room and board to the boarder are excluded.

Income of Resident Farm Laborers, Migrant AG's, School Employees, and other Contractual Employees

- Resident Farm Laborer

    - Irregular Income - Single Employer

      In some instances, the AG is paid for work done only during the work season, but resides year round on the farm and may receive advance or deferred payments, (sometimes known as "furnish"), during the non-work season. Some difficulty may be experienced in assigning an income figure to the farm worker whose income is high during the work season and correspondingly low during the non-work season when income is only from advance or deferred payments. Irregular income is to be averaged over a 12-month period.

    - Regular or Irregular Income - Multiple Employers

      When a farm laborer works regularly for more than one employer, the total income from all employers must be determined and then it is treated in the same manner as that received from a single employer.

- Migrant Farm Laborer

  It must be determined whether migrants have out-of-state income from real property in the home base area. A migrant family is permitted one home and lot as an exemption from resources as any other AG. The income of children in migrant households will be treated as that of any other child for whom eligibility is being determined. If the amount of income belonging exclusively to a child cannot be determined, prorate equally the total income of all household members and treat the child's pro-rata share as her/his own income.

- School Employees

  The average monthly income of school employees will be considered available during the months it is received. Please note that some school employees are paid 9 months of the year, some are paid 10 months, and some receive pay 12 months. The caseworker must determine the pay arrangement a school employee may have so that income can be considered in appropriate months.

- Income of Other Contractual Employees

  The average monthly income of persons employed on a contractual basis (other than school employees) will be considered as income during the period covered by the contract.

- Temporary Employment of Person Under Contract

  In some instances, an employee under contract may accept temporary employment. For example: many teachers and other school employees accept temporary employment during the summer months. After the appropriate earned income exclusions, disregards and deductions, income from temporary employment will be budgeted as available only in the months received. The same procedures outline in the section below on Unemployment compensation will be followed.

- Unemployment Compensation for Annual Contract Employees

  Employees with annual contracts such as school employees may be eligible for unemployment compensation when their employment ends. The A/R must be questioned to determine:

  - whether or not he/she has filed a claim for unemployment compensation benefits;
  - if benefits are being received; and
  - the amount of the benefits.

  Count unemployment compensation as income only in the months in which it is received. Do not annualize unemployment compensation benefits with income from contractual employment. The monthly amount of the unemployment compensation benefit will be added to the annualized monthly income from employment to determine income available to meet current needs.

- FF Diversion Income

  When an AG applies for AFDC-MO and has received money from FF as Diversion Income, exclude this money as income in the month of receipt and count as a resource if retained the month following the month of receipt.

Budgeting Methodology

Budgeting Methodology for the Sibling Income or MA S category, Budgeting Methodology for the AFDC-MO 1931 category

For the AFDC-MO 1931 coverage group, policy that was in effect prior to the implementation of FF in July 1996 applies. In pre-1996 policy, the earned income disregard was the 30 1/3 disregard budgeting method. In order to simplify the budget calculation for this coverage group, DHS opted

to use the following special earned income disregard for 1931 Medicaid as more advantageous to the applicant/recipient:

Applicants and recipients for medical assistance as Categorically Needy in an AFDC-MO coverage group are subject to the Centers for Medicare and Medicaid approved earned income deduction.

To calculate the deduction,

- Select the Families First Consolidated Need Standard (CNS) for the appropriate Aid Group (AG) size.
- Subtract ninety dollars ($90) plus thirty ($30) or one hundred and twenty dollars ($120) from the Families First CNS for the AG size.
- After deducting one hundred and twenty dollar ($120) from the CNS, subtract one-third (1/3) of the balance of the CNS.
- Subtract the entire amount of the current Families First standard earned income disregard to arrive at the AFDC-MO earned income deduction.

EXAMPLE: Current CNS for Aid Group size one (3) $1066

Step 1: Subtract $90 + $30 or $120 from $106 ($1066 - $120 = $946).
Step 2: One third (1/3) of $946 is $315. ($946 - $315 =$631)
Step 3: $631 - $250 (Families First standard earned income disregard) is $381 ($381 is the AFDC-MO earned income disregard for a 3 person AG size).

Eligible AFDC-MO applicants and recipients with earned income receive the Families First standard earned income disregards plus the AFDC-MO earned income disregard. In the above example, the AFDC-MO individual would receive a combined earned income deduction of $359 ($250 Families First standard earned income disregard and $109 AFDC-MO earned income disregard).

"1931" AFDC-MO Earning Disregards

AG SIZE	DISREGARD AMOUNT		AG SIZE	DISREGARD AMOUNT		AG SIZE	DISREGARD AMOUNT
1	359		8	860		15	1092
2	487		9	916		16	1116
3	582		10	943		17	1138
4	645		11	977		18	1156
5	733		12	1009		19	1171
6	777		13	1038		20	1181
7	827		14	1066			

Resources

The same resource limitations apply for FF, MA S, and 1931 Medicaid cases:

- $2000 resource limit
- Vehicle equity value of $4600
- Exclusion of IDAs and Low-Income entrepreneurial escrow accounts up to $5000

Procedures

If the aid group is not eligible for FF, or 1931 AFDC-MO coverage, then determine eligibility in other TennCare Medicaid categories.

Review AFDC-MO 1931 cases annually. Clients will be expected to report changes within 10 days. Recipients who are AFDC-MO ineligible due to increased earnings or work hours will be eligible for 12 months of transitional Medicaid. However, in order to qualify for transitional Medicaid when AFDC-MO closes, the recipients must have received AFDC-MO for three of the last six months, and closure must be due to increased earnings or hours of employment.

TRANSITIONAL MEDICAID (TM)

If the AG is closed for earnings or increased work hours, the AG will be given 12 months of Transitional Medicaid. Once eligible for TM, the AG will continue to receive TM throughout the initial six-months unless the AG moves out of the state or an AG member dies or the only dependent child leaves the home.

NOTE: In order to continue eligibility for TM, the AG must contain an eligible child.

Initial Six-month - Transitional Medicaid

The AG must have been eligible for and received AFDC-MO at least three out of six months immediately preceding the month of ineligibility.

Once eligibility for TM is established, the AG will continue to receive TM benefits throughout the initial six-month transitional period with the following exceptions:

- The assistance group moves out of the state; or
- The death of assistance group members.

Second Six-month TM Eligibility Requirements

- The family must have been income eligible for each of the initial six months of TM.
- The family must include an eligible child living in the home and the child does not have to be deprived of parental support.
- The family must report timely any changes on their quarterly report form by the 21st day of the fourth month in the initial six-month transition period unless there was good cause.
- The caretaker relative must have had earning in each of the initial six-months of TM unless the lack of earnings was due to an involuntary loss of employment, illness or other good cause reasons.
- The average gross earnings during the initial six-month period do not exceed 185% of the federal poverty level per assistance unit size (see FA desk guide).

NOTE: The first month of eligibility for TM is the first month of ineligibility for AFDC-MO rather than the effective month of closure.

EXAMPLE: Ms. Ferris has been eligible for and has received AFDC-MO three of the proceeding six months. She became employed on March 30 and received her first check April 6. Ms. Ferris receives four checks in April. Her earnings in April are sufficient to cause prospective ineligibility. If she timely reports this income change, her case will be closed effective May 1. If she does not report the change until her review in July, her case will be closed effective August 1. But, the first month eligibility for TM would be in April in both instances.

Quarterly Reporting

Individual's eligible for TM is responsible for submitting a quarterly report form.

- DHS will generate a periodic report (QR) form to each TM family for each report period. This form will be mailed out at the end of the 3rd, 6th and 9th month.
- The TM recipient will complete the form and return it by the 21st of the fourth month to cover any changes in income which occurred in the 1st, 2nd and 3rd months; by the 21st of the seventh month to cover any changes in the 4th, 5th and 6th months; and by the 21st day of the tenth months to cover month 7, 8 and 9.
- Notify the TM recipient this form must be return by the 21st day of the fourth or the 21s day of the seventh month or the 21st day of the tenth month to their eligibility worker if there were any changes in the family's gross income for the three month period. If the caretaker's gross income exceeds 185% of the poverty level income standard per family size or the AG resources exceed the limit or the only eligible child leaves the home, terminate the TM coverage.

To determine average gross income, add together the total income received in each month of the three month period, divide the total by three to arrive at the average gross income.

EXAMPLE: Ms. Ferris has been eligible for and has received AFDC-MO three of the preceding six months. She reports she has gotten a raise at work. She now earns $1900 for the month July '07 and causes ineligibility for AFDC-MO. She is given Transitional Medicaid beginning in August '07. The second report form is generated in February '08 and is returned by March 21st. She reported her income increased to $2200 monthly. The 185% PLIS standard for a household of three is $2647. Because her earnings remain under the PLIS standard the TM coverage continues.

EM for Child and Spousal Support Closures

When an AG is terminated due to receipt or an increase in child or spousal support, the AG members are eligible for 12 months of EM and there is no special reporting requirement when AG coverage is terminated due to receipt of child or spousal support. Specific reason codes will distinguish the difference between EM and TM. Continue to use reason code 042 for TM approvals and reason code 044 for EM approvals.

The AG must have been eligible three out of the six-months prior to the month of ineligibility. The first month of ineligibility is the effective month of closure (if notification of the support collection is received timely). If it is not reported timely the initial month of EM would be the initial month of ineligibility.

EXAMPLE: Ms. Johnson and her two children are receiving AFDC-MO. The CNS for three is $963. After 6 months of receiving AFDC-MO, Ms. Johnson reports on May 16, 2007 her x- husband has been order to pay $1200 a month in child support beginning June 1, 2007. This will close her AFDC-MO case effective June 30. Ms. Johnson is eligible to receive EM effective July 1, 2007 and ending June 30, 2008.

EXAMPLE: Ms. Johnson and two children are receiving AFDC-MO. The CNS for three is $963. After s6 months of receiving AFDC-MO, Ms. Johnson reports on May 16, 2007 she began receiving child support in the amount of $1200 a month on March 1, 2007. This would have caused in eligibility March 30, 2007. Although Ms. Johnson failed to report her child support timely, she is eligible for EM beginning April 1, 2007 and ending April 30, 2008

Extended Medicaid for a Pregnant Woman

Extend Medicaid coverage for two calendar months following the month a verified pregnancy ends, or throughout a woman's pregnancy and two calendar months following the pregnancy ends for a pregnant woman who became ineligible for AFDC, regardless of the reason for ineligibility.

PREGNANT WOMEN, NEWBORNS, CHILDREN OF A CERTAIN AGE

Policy Statement

Legal Base: Sixth Omnibus Budget Reconciliation Act of 1986

Categorically Needy TennCare Medicaid benefits are available to pregnant women, infants to age one, and children over the age of one to a specified age whose gross countable income is equal to or less than a specific percentage of the federal poverty level as defined in this Chapter and who meet certain technical requirements.

Periods of Coverage

The pregnant woman who is initially determined eligible prior to OR during the month of the child's birth, spontaneous abortion OR termination of the pregnancy, remains TennCare Medicaid eligible, regardless of the change in the family income:

- Throughout the pregnancy, AND
- For two calendar months following the month the pregnancy ends (i.e. automatic postpartum coverage).

Post partum coverage is provided when the pregnant woman has applied and is eligible prior to the end of the pregnancy. This coverage is also extended to the pregnant woman who is terminated for TennCare Medicaid in another category but would have been PLIS eligible as a pregnant woman at anytime while receiving TennCare Medicaid in the other category.

The child is covered to a specific age, currently to age 19. TennCare Medicaid coverage under this category continues until the child attains the specific age as long as the child remains income eligible.

Technical Eligibility Requirements

Refer to the appropriate Chapters in this Manual for a full discussion of these policies, methods of verification, and related procedures.

- Prohibition against concurrent receipt of TennCare Medicaid benefits.
- U. S. citizenship requirement
- Tennessee residency requirement

- Enumeration requirement - Prior to approval, the pregnant woman is required to provide or to apply for a Social Security number. The newborn is not required to be enumerated until the child reaches age one.

- Age - There is no age limit for pregnant women. The child may be eligible through the month of the nineteenth birthday.

- Newborn
  Legal Base DEFRA Section 2362

  A newborn is deemed automatically eligible (no income test) for TennCare Medicaid up to age one if he continues to live in his mother's household and:

  - he is born to a TennCare Medicaid eligible woman, OR

  - the mother was Medicaid eligible at the time of the birth and would have remained eligible if pregnant.

  A newborn or child under age one whose mother was not Medicaid eligible is not automatically eligible and must meet the income guideline.

- Striker Policy - If the pregnant woman or her spouse or the parent(s) of certain children of a specified age is on strike the last day of any month for which coverage is requested, the woman and, after its birth, the newborn and children of a specified age may be eligible for TennCare Medicaid if all eligibility requirements are met under the poverty level coverage groups.

- Confirmed Pregnancy - Written medical verification of pregnancy is required. An acceptable pregnancy verification has the following characteristics:

  - prepared and signed by medical personnel such as a physician, nurse, midwife practitioner, health clinic personnel, etc.

  - includes the estimated dates of conception, delivery, and current month of pregnancy.

  - Includes the date the verification was prepared.

Financial Eligibility Requirements

Refer to the appropriate Chapters in this Manual for a full discussion of these policies, methods of verification, and related procedures.

- Application for other benefits

- Assignment of rights to all third party medical support

- Financially responsible relatives - There is no deeming for this budget group.

- Income - Refer to the Income and Treatment of Income Chapters for definitions, policies, verification procedures and other information regarding income and determining countable gross income for these groups. The Families First Handbook may also be reviewed as the FF definition and exclusion of income are applied for these groups.

Income Standards

- Children of a Specified Age (age 6 to age 19) – 100% PLIS

  One hundred percent (100%) of the federal poverty level is the income standard used to determine categorical income eligibility for certain children age 6 to age 19. If children within the specified age limits are not PLIS eligible, determine eligibility under Families First, other categorical coverage (such as MA S, AFDC-MO, Pass Along/Pickle), and/or all applicable Medically Needy programs.

- Children of a Specified Age (age 1 to age 6) – 133% PLIS

  One hundred thirty three percent (133%) of the federal poverty level is the income standard used to determine categorical income eligibility for certain children age 1 up to age 6. If children within the specified age limits are not PLIS eligible, determine eligibility under Families First, other categorical coverage (such as MA S, AFDC-MO, Pass Along/Pickle), and/or all applicable Medically Needy programs.

- Pregnant Women and Infants to age one – 185% PLIS

  One hundred eight five percent (185%) of the federal poverty level is the income standard used to determine categorical income eligibility for pregnant women and infants up to age one. If children within the specified age limits are not PLIS eligible, determine eligibility under Families First, other categorical coverage (such as MA S, AFDC-MO, Pass Along/Pickle), and/or all applicable Medically Needy programs.

Resources

Resources are NOT considered in determining eligibility for these coverage groups (i.e., Pregnant Women and Infants and Children of a Specified Age.)

Current PLIS levels are published on the DHS Intranet site at www.intranet.state.tn.us/dhs/desk-guide.pdf for DHS staff. This information is also available at aspe.hhs.gov/poverty/index.shtml.

Budgeting Methodology

Determining income eligibility requires defining the budget group (who is included), applying appropriate income exclusions, and comparing the gross countable income to the income standard for the budget group size.

Define the Budget Group

- Pregnant Women and Infants to Age One

  The pregnant woman and/or infant to age one are the only eligible individuals. Their eligibility is based on a specific percentage of the poverty level for the family size as defined earlier. Include in the budget group the needs and income of:

  - the pregnant woman
  - the infant to age one
  - the unborn(s) when medically verified that there is more than one fetus
  - the pregnant woman's spouse, if living in the home
  - the pregnant woman's other children living in the home (whole, half or step siblings to the unborn(s) whose income does not negatively affect the pregnant woman's eligibility)

  When budgeting families with children of various ages that require the use of different percentages of the PLIS (100%, 133%, 185%), separate budgets may be calculated leaving out one or more children whose income may adversely affect eligibility. The parents (if present in the home) must be included in each budget group. The step parent may be included if, this is to the family's advantage.

  NOTE: The data base will form different aid groups by using sequence numbers. Example: MA J 01, MA J 02.

- Certain Children of a Specified Age

  Eligibility for a child over age one under a specific percentage of the poverty level as defined earlier is determined based on family size and income. However, the child within the specified age limit is the only eligible individual. Include in the budget group the income and needs of:

  - the child(ren) of the specified age limit AND
  - his/her parent(s) living in the home AND
  - the child's sibling(s) who do not have sufficient income to cause the child's ineligibility.

  NOTE: There is no deeming for this coverage group. The step parent may be included if, this is to the family's advantage.

- Eligibility for Other Family Members

  TennCare Medicaid eligibility for other family members who are not pregnant must be determined as categorically needy under Families First, other categorical coverage, such as AFDC-MO, MA S, or Pass Along/Pickle.

  Children age 19 to 21 should have their eligibility determined for the Medically Needy program. Non-pregnant adults are not eligible for Medically Needy coverage.

Exclude Recipients of Public Assistance

Exclude from the budget group any individual and his income who receives Families First cash assistance or SSI payments. Do not count the FRR's income from a VA needs-based pension or other income used to determine the amount of the pension.

Apply Excluded Income Provisions

Exclude any income belonging to budget group members as described in this Manual.

Determine Total Gross Countable Income

Combine individual total gross countable incomes received in the month of application with all budget group members. Count only the pro rata share of the income of the pregnant woman's spouse if they were married during the application-processing period.

EXAMPLE: The pregnant woman is married on the 25th day of a 30-day month. Her husband has income of $1200 for the application month. 1200 divided by 30 days = $40/day x 6 days = $240 countable pro rata share of income for the month of marriage. The only disregard of income special to this category is the $50 child support disregard.

Compare Gross Income to Need Standard

Compare the gross income obtained to the specific percentage of the poverty level, depending on the aid group composition, to the family size as determined earlier. If a family has both a pregnant woman/infant to age one and children of a specified age, a budget test for each group must be completed, using the appropriate PLIS. The same family members may be used to determine family size for each budget (i.e., work each budget as if the other budget does not exist). If the gross income is equal to or more than the applicable PLIS, see the next step for Families First or Medically Needy eligibility.

Families First and/or Medically Needy (MN) Eligibility

If the budget group is not eligible after completion of the steps above, determine eligibility for Families First cash assistance or other TennCare Medicaid categories as appropriate. See the Families First Handbook for policies and procedures. See the Medically Needy Chapter in this Manual for MA T (the data base category) eligibility for pregnant women and children to age 21 only.

Application Process

Complete the eligibility determination and send the applicant a written notice of the decision within 45 days of the application filing date.

Eligibility Dates

TennCare Medicaid eligibility for the technically and financially eligible woman/infant and certain children begins the date of application or the date in which all eligibility requirements are satisfied whichever is later.

- Ending Dates for Pregnant Women

  TennCare Medicaid eligibility ends 2 calendar months following the last month of the woman's pregnancy. This 2-calendar month postpartum period is automatic and applicable to all pregnant women who have applied, received, and been eligible for TennCare Medicaid prior to the end of the pregnancy or during the last month of pregnancy. An ex-parte review is required prior to closure to determine if eligibility in any other category of Medicaid exists.

- Ending Dates for Infants

  TennCare Medicaid eligibility for infants must be redetermined when the child reaches age one (the month of the child's first birthday). Income eligibility must be tested first against a lower percentage of the PLIS as a child of a specified age.

  If not financially eligible when tested against the appropriate PLIS, all other appropriate categories must be tested. Remember that the child is required to have a SSN prior to being approved for coverage in another category. An ex-parte review is required prior to closure to determine if eligibility in any other category of Medicaid exists.

- Ending Dates for Certain Children of a Specified Age

  TennCare Medicaid eligibility for children attaining age 6 must be redetermined using the lower PLIS standard during the month of the child's sixth birthday. A data base alert is received by the caseworker, Alert 324. TennCare Medicaid eligibility ends when the child

reaches the specified age level, which at the current time is age 19. An exparte review is required prior to closure to determine if eligibility in any other category of Medicaid exists.

Adding the NEWBORN to the case

The newborn children of eligible members of the pregnant woman group are automatically extended TennCare Medicaid benefits upon their birth, if the mother was TennCare Medicaid eligible at the time of the birth and the child continues to live with the mother. This includes babies born to undocumented aliens who were eligible for emergency TennCare Medicaid benefits only. Effective upon release of Bulletin No. 22 (MA-07-15) dated May 02, 2007, this policy also includes babies born to undocumented aliens who were eligible for emergency TennCare Medicaid benefits only. The beginning date of eligibility is always the child's date of birth. The infant continues to be eligible if all eligibility requirements are met, until the child reaches the specified age shown above.

Adverse Action Procedures

For adverse action procedures, observe all adequate and advance notification requirements as specified in this Manual. An adequate notice for removing an individual or closing this type of case is one that includes:

- A statement of the intended action and its effective date.
- The reason(s) for the intended action.
- Citation of specific regulations, rules, or laws supporting it.
- The client's right to appeal the action and an explanation of the circumstances under which benefits continue pending an appeal decision.
- Notification of possible eligibility in another coverage group and/or advice to the mother regarding application for continuing benefits.

Presumptive Eligibility for Pregnant Women

Legal Base: Section 1920 of the Social Security Act

Presumptive eligibility is temporary TennCare Medicaid coverage for pregnant women which are authorized by a qualified medical provider. The presumptive eligibility program was implemented in Tennessee in 2-1-89 and is a collaborative effort of DHS, the Bureau of TennCare, and the Department of Health. Other pertinent facts regarding presumptive eligibility (PE) follow:

- One period of PE is authorized per pregnancy.
- The PE period is 45 days.

- Only ambulatory services are covered (not delivery or hospitalization).
- There is no test for resource eligibility.
- The financial standard is the same as that used for the Pregnant Woman PLIS category.

All Public Health Departments in Tennessee, as well as those health care providers listed at the end of this section, are qualified medical providers. The qualified medical provider screens all pregnant women they serve and:

- Determines if the client is currently TennCare Medicaid eligible.
- Obtains verification of the pregnancy.
- Processes the Medicaid Presumptive Eligibility Form
- Assigns a Presumptive Eligibility (Recipient) ID #
- Completes the authorization part of the PE form.
- Mails a copy of the PE form to the Bureau of TennCare for each PE approval.
- Provides the regular DHS Family Assistance application form (HS-1069) to be completed and signed by the pregnant woman.
- Mails a copy of the PE form and the application form immediately to DHS.
- Allows the pregnant woman to select a Managed Care Organization (MCO).

The DHS caseworker uses the date of receipt of the application in the county office as the beginning date of eligibility for program benefits. He/she determines eligibility for TennCare Medicaid within the 45-day period of presumptive eligibility to avoid lapses in coverage.

The DHS caseworker front desk staff or Family Assistance Service Center may refer pregnant women applying for assistance in the county DHS office to the local public health office or other qualified medical provider if the need for medical assistance is urgent. He/she explains that PE may be authorized only once per pregnancy.

Each local DHS office is responsible for developing plans with qualified medical providers for providing the FA application form and Request for Verification Forms (if agreeable with the provider) to clients, for mailing the completed applications to DHS, and for DHS referrals to the qualified Medical Provider for PE determinations.

The following individuals or agencies may be used for presumptive eligibility determination. These are IN ADDITION TO the local Public Health offices or the Department of Health and Environment. This list was updated 12-2-1999.

QUALIFIED PROVIDER	PHONE NUMBER	COUNTY/COUNTY #
Indian Mountain Clinic Jellico, TN 37782	423-784-5771	Campbell/07
Regional Medical Center at Memphis Memphis, TN 38103	901-545-7100	Shelby/79

Memphis Health Center Memphis, TN 39126	901-774-7773	Shelby/79
Maternal & Infant Care Clinic Metropolitan General Hosp. Nashville, TN 37210	615-341-4233	Davidson/19
Monroe Maternity Center Madisonville, TN 37354	423-442-6624	Monroe/62
Rural Health Services Consortium of Upper East Tennessee, Inc. Rogersville, TN 37857		
– Mountain City Medical Clinic	423-727-6319	Johnson/46
– Rogersville Medical Clinic Rogersville, TN 37857	423-272-5600	Hawkins/37
United Neighborhood Health Services Nashville, TN 37206	615-228-8902	Davidson/19
– Cayce Medical & Dental Clinic Nashville, TN 37206	615-226-1695	Davidson/19
– Hartsville Family Health Center Hartsville, TN 37074	615-374-2107	Trousdale/85
– Waverly-Belmont Medical Ctr. Nashville, TN 37203	615-269-3461	Davidson/19
Matthew-Walker Health Center Nashville, TN 37208	615-327-9400	Davidson/19
Mountain People's Maternity Center Huntsville, TN 37756	423-663-2740	Scott/76
Greenlaw Center Memphis, TN 37105	901-775-2000	Shelby/79
Rossville Health Center Rossville, TN 38066	901-853-2291	Fayette/24
Vine Hill Community Clinic Nashville, TN 37204	615-292-9700	Davidson/19

MEDICAL ASSISTANCE FOR CHILDREN (MA T)

Medically Needy for Families and Children

Policy Statement:

Legal Base: 42 CFR 435.300
State Rule: 1240-3-2-.03

TennCare Medicaid benefits are available to the **child** who meets the technical eligibility requirements and is **under age 21**, has countable income equal to or less than the appropriate Medically Needy Income Standard (MNIS) for the budget group size, or has met the Spend down requirement, and has resources within the Medically Needy resources limits based on the budget group size.

A pregnant caretaker or under age 21 caretaker may be included in the aid group.

NOTE: When processing through the data base, the system will not form the MA T group to include a pregnant or under age 21 caretaker for a child eligible under a MA J category or a SSI eligible child. This group must be created by an override through the data base.

Eligibility for medically needy is determined when an application is filed but the aid group is ineligible for Families First because of a requirement which does not apply to Medicaid, or the aid group applies for but is ineligible for FF because of income or resources that exceed the FF limits. Eligibility is first tested for pregnant women and children under age 19 in the PLIS category.

Enrollment for non-pregnant adults age 21 and over was closed April 29, 2005. This affects eligibility for adults applying on behalf of children under age 21 in the MN category. Currently, only caretaker relatives who are pregnant or under age 21 may be included in the AU with MN children. Because of this, deprivation of a child based on absence, incapacity or underemployment is not currently relevant policy in the MN category.

Overview of Eligibility Requirements

Listed below are the Technical Requirements that apply to this category but are covered elsewhere in this Manual. These chapters must be reviewed and the appropriate policy and procedures applied to accurately determine eligibility in this category.

- Prohibition against concurrent receipt of program benefits
- U.S. citizenship or qualifying alien status
- Tennessee residency
- Provision of or application for a Social Security number
- Prohibition against strike participation
- Disqualifying Living Arrangements
- Application for other benefits
- Assignment of third party medical support

- Financially responsible relatives

The following eligibility requirements do not have a separate chapter in this Manual and are applicable to this category of coverage:

Eligibility Requirements

Age - Legal Base: 42 CFR 435.520

The medically needy child must have a verified age of under 21 years. Caretakers, in order to be included in the aid group, must have a verified age of under 21 or be pregnant. The unborn child, who would be technically and financially eligible for benefits if born, is eligible for budget group membership if the pregnancy is verified. An unborn child is not eligible for aid group membership. Budget group membership allows the unborn's needs to be included in determining the group's financial eligibility which is reflected in an increase in both the Resource Reserve Limitation and the Medically Needy Income Standard. If medically verified that there is more than one fetus, use the MNIS that reflects the needs of each fetus.

Include the unborn in the budget group, if pregnancy is verified on the date of application or the date of eligibility, whichever is later, but no earlier than the estimated date of conception.

Acceptable pregnancy verification has the following characteristics:

- Prepared and signed by medical personnel, e.g., a physician, nurse, health clinic personnel, etc.;
- Includes estimated dates of conception (EDC) and delivery (or confinement);
- Includes the current estimated month of pregnancy;
- Includes the date the written verification was prepared.

Relationship

Legal Base; State Rule: 1240-1-3-.20

The medically needy child must be living with a relative who is within the degree of relationship specified by the law only when the relative has requested inclusion. Due to closed enrollment for MN adults on April 29, 2005, only caretaker relatives who are pregnant or under 21 may be included in the AU. Relationship verification is also required to determine legal responsibility for budgeting purposes. A relative within the "specified degree of relationship," which is the fifth degree, are listed below.

- Any blood relative, i.e. father, mother, brother, sister, uncle, aunt, first cousin, nephew, niece, or first cousin once removed. This includes relationships to preceding generations, grandparents, great-grandparents, great-great grandparents, great uncles/aunts, and great-great-great grandparents.

- Any of the above relatives who are of half-blood relationship.

- Stepfather, stepmother, stepbrother and stepsister.

- Legally adoptive parents of the child or of the child's parents, the natural and other legally adopted children of such persons, and the blood relatives of such persons, including first cousins, first cousins once removed, nephews and nieces.

- Legal spouses of any of the persons named in the above groups. This applies even though the marriage may have been terminated by death or divorce. The caretaker relative does not have to be the legal guardian or custodian of the child in order to receive benefits as the caretaker for the child. Blood relationship within a specified degree of the child and relative is the eligibility requirement for MA T purposes.

Relationship Terms

- **Adoption of children** - Legal adoption of a child or a child's parent establishes a legal relationship to a new set of relatives, both immediate and extended. The adoptive relatives within the specified degree of relationship qualify to receive benefits for an adopted child as do the blood relatives of the adopted child.

- **Child Born of Annulled/Bigamous Marriage** - Children born of an annulled or bigamous marriage are considered the legal children of that marriage.

- **Child Born During Marriage** - By law in Tennessee, any child born during a marriage or within ten months of the termination of that marriage by death or divorce is presumed to be the child of the mother's husband. This presumption can be overcome only by strong and convincing evidence that it would have been impossible for cohabitation between the mother and her husband to have occurred at the time of the child's conception. Therefore, when a child is born in these circumstances, the mother's husband will be considered to be the child's father. This is true, even if it is alleged that someone other than the husband is the child's father, until paternity is established in a court of competent jurisdiction.

- **Legitimated Children** - Children who have been legitimated are entitled to all rights and privileges of a child born in wedlock. Therefore, relatives of the legitimating parent are considered as relatives eligible to receive MA T for the child.

- **Termination of Parental Rights** - Termination of parental rights by a court of competent jurisdiction terminates all of the rights and responsibilities of a child's parents. However, such termination does not affect a child's relationship to his/her natural extended family. When blood relationship to these relatives can be factually established, they may receive MA T for the child.

Relationship must be verified before the eligibility of a caretaker (who is pregnant or under age 21) can be approved. Once the relationship is verified, it is not necessary to verify relationship again unless the information becomes questionable. Verification is primarily the responsibility of the

caretaker except when the information is already known to the Department or when it is more reasonable for the caseworker to obtain the needed information.

The following documents can be used to verify relationship whether legal or alleged. When any document other than a birth certificate or birth data obtained through Tennessee Clearinghouse is used to establish relationship, more than one document is required:

- Birth certificates, copies of birth certificates or Tennessee Clearinghouse which establish relationship of the child to his/her parent; (In instances where the caretaker relative is not the parent, these documents can be used to verify the relationship of the caretaker relative to the child's parent. This is a preferred form of verification, but is not required.)

- Adoption and legitimation orders that establish the relationship of the child to his/her parent;

- Hospital birth records;

- Family bible or other family records which are in ink and have not been altered;

- Trust documents and other such instruments and/or records if relationship is specified in the document;

- Wills and deeds to property if the individuals and relationships are specified;

- Census bureau records that list the child belonging to a particular family and showing relationships;

- Written statements of physicians or midwives who attended the births and remember the names of the people involved;

- Social agency records including those of DHS which are at least one-year old and which consistently specify the degree of relationship of the applicant/recipient to the child;

- Juvenile court, other court and hospital records which show relationship;

- Copies of income tax returns listing the child as a specific relative;

- School records which specify relationship;

- An award letter or other acceptable evidence from SSA that RSDI payments have been awarded to a child based on his/her parent's account;

- Military or veterans records which specify relationships;

- INS records, Indian agency records, other government or local agency records;

- Newspaper records, and local histories which specify relationship;

- An acknowledgement of paternity properly completed by an alleged natural father of a child is sufficient substantiation of blood relationship; or

- Written materials of other kinds may be used as cumulative evidence of relationship when names and relationship are specified. Such materials include church, daycare and school records, letters and other such written materials.

In the absence of any documentary proof of relationship, the caretaker relative's statement is acceptable as long as it contains the following information:

- the reason there is no proof of relationship;

- his/her detailed statement as to how he/she is related to the child;

- as least one notarized statement from a person in a position to know the facts of the situation in which he/she describes the relationship and how he/she knows it to be true.

The notarized statement that is used may be either written by the individuals providing the information, or DHS staff can write out the statement and have the individuals' signature notarized. These affidavits may be used to fill in gaps in the information verified by documentary evidence or in lieu of documentary evidence if none exists. An affidavit tracing relationship must be made by a person other than the applicant/recipient. This person may be related or not related to the AR, but he/she must be a person who is in a position to know the facts of the situation. More than one affidavit may be required in order to completely trace relationship.

All information regarding relationship must be documented on the appropriate data base screens. Any other pertinent information regarding relationship must be documented on running record comments. For example, once the relationship is verified, it is not necessary to verify relationship again unless the information becomes questionable. If that occurs, the caseworker must document the electronic case record regarding the questionable circumstances and the outcome of the verification.

The caseworker must evaluate the evidence used to establish relationship as to its validity, consistency and the credibility of the person providing the information. Any conflicting information must be resolved before approval of a MA T application. The caseworker must obtain any available information necessary to constitute a preponderance of consistent evidence of relationship to determine the relationship of the child to the caretaker. Each step of the relationship between the child and caretaker must be traced and documented. Do not use an affidavit to show relationship when documentary evidence is available or can be obtained.

A non-relative may apply for MN coverage for a child under age 21. Relationship has no bearing on the child's potential eligibility, only on the potential inclusion of the caretaker.

Dependency

Legal Base: 42 CFR 435.510; State Rule: 1240-3-3-.02 (7)

Dependency of a child must be determined in order to include an individual as a caretaker (who is pregnant or under age 21) in the aid group. To include a caretaker in the aid group, the child must live with the individual who is within the specified degree of relationship and have primary responsibility for care and control of the child.

- Living in the Household

  This section applies only to caretakers who are pregnant or under age 21. To be eligible to receive medically needy Medicaid, the caretaker of a child must live in a place of residence maintained by a specified relative as his or her home and the home of the child. Legal custody is not pertinent to the determination of eligibility and relationship. Where the child actually lives and who has care and control of the child is the determining factors.

- Care and Control

  A relative is considered to have **care and control** of child when he/she has the major responsibility for parental obligations of day-to-day care, support, supervision and guidance for the child. These responsibilities may be carried out either alone or with another person living in the home. When the child lives with the relative, it is presumed that the relative has care and control of the child.

  However, there are certain situations when this may be questionable, and the caseworker must determine who has care and control of the child. The following are examples of instances when care and control must be established:

  - joint custody cases;
  - when the relative and the child live in different dwellings;
  - when temporary absence is claimed; and
  - when a relative who is not the parent receives benefits for the child and a parent return to the home.

  The decision as to if the relative has care and control of a child is made on a case by case basis. The caseworker/supervisor must evaluate the facts in each particular situation and use their best judgment. If the facts establish that the relative has care and control, then the child is considered to be living with that relative.

- Joint Custody

  When there is a situation of **joint custody**, the caseworker must look at each situation on a case by case basis. The child would be considered to be living in the home of the parent with whom he/she resides at the time of application. When the child goes to live with the other parent, eligibility ceases to exist with the first parent.

- Temporary Absences

  Eligibility can continue during temporary absences from the home for either the child or the relative. A temporary absence of the child or relative is of short duration with specific intentions of returning on or about a specific date. In addition, the relative must continue to provide care and control of the child even though either the child or the relative is temporarily absent from the customary family setting. Any absence of either the child or relative which will extend beyond three months must be studied carefully to determine if the relative actually retains care and control of the child for a major portion of each month.

  Some examples of when benefits can be granted or continued for a child who is temporarily out of the home are when the child

  - is away on a visit;

  - is in the hospital temporarily for treatment;

  - attends summer camp;

  - attends an accredited or approved school away from home for the primary purpose of academic education or vocational/technical training because the school facilities to meet this child's special needs are not available in his/her own community or within commuting distance;

  - attends a college, university or other vocational school on a scholarship or other grant that is not available in his own community;

  - is temporarily in a psychiatric facility and has not been placed there by a court order; or

  - is in a maternity home

  A child with special needs includes one who is especially gifted in a particular area such as an academically gifted or artistically gifted child or one who has a physical, mental, and emotional or learning disability. A facility that is established primarily for the purpose of providing child care or which is licensed for that purpose does not qualify as an accredited or approved school regardless of what the facility might be called.

  Some examples of when benefits can be granted or continued for a relative who is temporarily out of the home are when the relative:

  - is away on a visit;

  - is providing some care for a spouse or child who is hospitalized;

- is attending a specialized training facility not available in his/her home community such as those through the Services for the Blind or Division of Vocational Rehabilitation;

- is in the hospital for treatment of an acute illness or injury;

- is in a maternity home;

- is in a convalescent care facility for the purpose of obtaining special care that is not available in the home;

- is absent for the purpose of setting up a home to which he/she will move the child; or

- is temporarily in a psychiatric facility and has not been placed there by a court order and will be absent for no more that six months.

A person who resides in a **maternity home** may be eligible for benefits. Eligibility is determined as though she was currently living on her own or in a foster home. The period of time spent in a maternity home is a temporary absence from her usual home and eligibility is established based on the circumstances that exist there. If the home situation is being dissolved, eligibility is determined based on the situation as it currently exists. Residents of a maternity home may apply either in the county of their usual residence or in the county where the maternity home is located.

Current school records showing the address of a school age child are the primary evidence that the child in the home of the relative requesting benefits. However, if the child is not school age or the school records are unobtainable for a school age child, use the following sources of evidence:

- Hospital, clinic, or Health Department records

- Statement from a child care provider

- Court support order;

- Juvenile court records.

- Child Welfare agency records.

- Statement from a minister, priest or rabbi.

- Signed statement from a non-relative

- Signed statement from a non-relative landlord.

- Personal contacts by the case manager with neighbors as to where, to their knowledge, the child lives; or

- Caseworker observation that the child lives in the home.

All information and verification about where the child lives, temporary absence, joint custody, etc. must be recorded on the appropriate data base screens and in the history section of the data base. All extenuating circumstances and/or unusual situations must be fully explained and must include all information used by the caseworker/supervisor in making decisions about whether or not the child meets the requirement of living with the caretaker/relative.

The following questions are guides to consider when determining if a relative has **care and control** of a child. The child's age and degree of independence are also factors in making this decision.

- Who has and exercises responsibility for daily physical maintenance of the Child such as purchasing/preparing food, purchasing/maintaining clothing, providing a place to sleep and basic shelter, and overseeing daily health maintenance activities?

- Who has and exercise responsibility for securing medical/dental care for the child?

- Who has and exercises responsibility for consenting to major medical treatment procedures for the child?

- Who receives and expends monies for the child?

- How many weeks in a month does the child stay in the relative's home? How many weeks in a month does the child stay away from the relative's home?

- What address is shown for a school age child on the school records?

- If a child is in day care, who takes the child to and picks the child up from the facility? Who does the daycare facility consider the responsible relative?

- Is the child included on the lease in public housing or does the landlord/rental agent know of his/her presence in the dwelling?

- Do other records indicate where the child lives?

When **joint custody** has been granted, the caseworker must:

- obtain a copy of the order or custody order, if possible;

- determine if the order is being followed;

- determine if both parents are functioning as parents;

- determine where the child spends the majority of the time;

- if the child is of school age, obtain from the school records the child's address and the name and address of the person to be notified in emergencies;

- determine if the child receives food stamps in the household in which he/she is included;

- ask neighbors, friends, relatives, etc. with whom they consider the child to be living; and

- determine who exercises care and control of the child.

The caseworker /supervisor will make their decision about where the child is living based on the information obtained through the sources listed above.

When determining **temporary absence**, the caseworker must establish:

- the name and location of the school, camp, maternity home or hospital where the person is;

- the name and address of the friend or relative the person is visiting;

- the date the individual left the home and the expected date of his/her return;

- the reason for the absence and the person responsible for the plans for the person to return to the home;

- the responsibility that the relative has for the child while either of them is away from the home, such as financial responsibility and decision making regarding the child's care; and

- specific arrangements for the individual's return to the home.

The caseworker will use this information to decide whether temporary absence exists or whether the person actually lives elsewhere. If temporary absence exists, an alert must be set to review the case when the individual is expected to return to the home.

Resources

Resource policies concerning types, verifications, countable and excluded resources, and availability of assets can be found in the Resources Chapter of this Manual.

Whose Resources to Count

Count the individually owned and pro-rata share of jointly owned assets of the children under age 21 or the pregnant woman for whom assistance is requested and their FRR.

Count the individually owned and pro-rata share of jointly owned assets of the parent under sentence to perform unpaid public or community service work while living in the home with the child(ren).

Do not include resources of a SSI or FF or other public assistance recipient.

Income

Income policies concerning countable/excluded/disregarded income, a discussion of earned and unearned income, verification methods, and budgeting methodology can be found in the Income Chapter and the Treatment of Income and Budgeting Chapter of this Manual.

Treatment of Income

Whose Income to Count

Count the income (except that subject to exclusion or disregard) of the following budget group members:

- Children under age 21 for whom assistance is requested, and
- Pregnant women for whom assistance is requested, and
- Their financially responsible relatives.

Count the income (except that subject to exclusion or disregard) of the parent serving a sentence of unpaid public or community service work while living in the home, less an amount equal to the MNIS for one to meet his/her needs.

Do not include income or needs of a SSI or FF or other public assistance recipient.

Caretaker on Strike

Legal Base: 1240-1-3-.60

The caretaker participating in a strike is ineligible; if the caretaker is the child's parent, the aid group is ineligible for benefits. This policy applies regardless of the parent's eligibility for aid group membership (pregnant or under age 21 only). If the aid group has been extended benefits a month in which the parent participated in a strike on the last day of the month, prepare an overpayment report as any TennCare Medicaid reimbursed services for any aid group member received during that month are subject to recovery.

Stepparent/Major Parent in the Home

The financial assets of a stepparent/major parent living in the home with budget group members are not available to the child(ren) for whom he/she has no financial responsibility. (Deeming applies only from spouse to spouse and parent to child.)

The stepparent/major parent's assets are considered available to his/her spouse/the minor parent, i.e., the child's caretaker (who is pregnant or under age 21). Determine the caretaker's eligibility for budget group inclusion by applying the following needs test (deeming budget) when the stepparent/major parent is not included in the budget group.

- Determine the stepparent/major parent's gross income and, if appropriate, apply the earnings disregards ($90 work expense allowance).

- Deduct the amount for dependent deductions which includes the MNIS for the stepparent/major parent and his/her in-home dependents, contributions for out-of-home dependents, and child support/alimony payments.

- If the net income is greater than the MNIS for the caretaker (who is pregnant or under age 21 and asking to be included), he/she has not satisfied the needs test and is not included in the budget group. The full amount of any income belonging solely to the caretaker who is a parent of budget group members is deemed available to the budget group when the caretaker's needs are met.

- If the net income is equal to or less than the MNIS, the caretaker has satisfied the needs test and is eligible for budget group inclusion. The subsequent financial eligibility determination considers only the caretaker's own individual income, resources, and pro-rata share of jointly owned resources (plus any belonging to the budget group members). The stepparent/major parent's financial assets are not deemed available to the caretaker if the caretaker satisfies the needs test.

Budgeting Methodology

- Define the Budget Group

  The budget group is composed of the following:

  - Children (including unborn children) who are technically eligible and for whom assistance has been requested; AND/OR

  - Parents of the above children who are not a SSI or FF recipients, AND do not have a FRR in the home who meets his/her needs, AND if not the child's parent, chooses inclusion on the basis of being pregnant or under age 21.

  The parent of children under age 21 must be included in the budget group unless his/her needs are met by a FRR, and he/she does not request to be included as pregnant or under age 21 caretaker. However, inclusion may be requested when needs are met by a FRR in the home.

- Exclude Any Recipient of Families First Cash Assistance

Exclude any budget group member and his individual income who receives FF cash assistance or SSI. These individuals are automatically entitled to TennCare Medicaid. Individuals receiving needs based VA pensions may be included in the aid group if otherwise eligible, and their income would be countable under those circumstances. If the individual with needs based VA pension is not included in the aid group, none of his/her income is considered available (deemed) to the aid group.

- Determine Individual Monthly Income

  Convert income received on other than a monthly basis to a monthly amount as discussed in the Chapter on Treatment of Income and Budgeting.

- Apply Income Exclusion

  Apply the income exclusions in the Chapter on Income, including the following:

- Earned Income Exclusion

  - JTPA earnings of a child recipient (exclude for up to 6 months per calendar year) AND

  - Earnings of a child who is either a full-time student or a part-time student, not employed full-time.

- Exclude the Child(ren) with Sufficient Income

  - A child with income may be excluded from the aid group if that child's income makes the budget group ineligible, and the child with income is not the ONLY eligible child.

  - Do not exclude any child whom the caretaker has identified as having special medical needs without first discussing the situation with the caretaker or the individual applying in the child's behalf.

- Apply Earnings Disregards

  Apply the earnings disregards described in the Chapter on Treatment of Income and Budgeting to the earnings of each budget group member in the following order:

  - Work expenses allowance of $90 per month.

  - Dependent care expenses necessary for continued employment up to a maximum of $175 per month per dependent age 2 or older or up to $200 per dependent under age 2.

- Determine Net Income

  Combine all net earnings and total gross unearned income of all budget group members.

- Rounding/Truncating

  Cents of all types are dropped during budgeting on the data base.

- Determine Exceptional Eligibility

  Compare the net countable income to the MNIS appropriate to the budget group size. If the net countable income is equal to or less than the MNIS, the aid group is "exceptionally" eligible. Authorize benefits for the aid group.

  NOTE: Pregnant women and children under age 19 should normally qualify in the PLIS category of Medicaid if income is at or below the MNIS.

  If the net income is greater than the MNIS, take these steps:

  - Determine if any of the children in the budget group has countable income. If this is the case, consult with the caretaker or other responsible party to determine if the child should remain in the budget group and have eligibility determined under the spend down provision.

  - If a child with income has been removed, test the remaining budget group members for exceptional eligibility. Exclude the individually owned resources of any child(ren) excluded in this or the next step when determining resource eligibility.

Determine Eligibility Under the Spend down Provision

The budget group with income greater than the MNIS may reduce its countable net income sufficiently to result in income eligibility for the aid group member(s) if the amount of incurred medical expenses offsets the amount of income in excess of the MNIS during the month.

Medical bills incurred during the month of application (whether paid or unpaid) or medical bills incurred within three calendar months prior to the application month (whether paid or unpaid) may be used.

Payments made on an "old bill" during the application month may be used toward spend down, regardless of when the bill was incurred. Only the amount paid during the month of application may be counted.

NOTE: An "old bill" is any bill incurred more than three (3) months prior to the month of application.

Payments made on a bill during the application month should be used before using the incurred expenses to meet spend down.

EXAMPLE: An individual incurred a $1000 medical expense in August of 2008. She filed an application at her local county office in October 2008, following news of her pregnancy. Based on her income, it would be necessary for her to have medical bills in the amount of $300 in order to be eligible for MN Medicaid. $300 of her $1000 medical expense can be used to fulfill her spend down obligation because the expense was incurred during the three months prior to the application month. $700 is left to be used for a future spend down, if it is still owed.

NOTE: This $1000 medical expense and the carry-over amount must be documented in the case record.

The next year she comes back for redetermination and states she is now 2 months pregnant. She still owes $700 from the medical expense she incurred during the three months prior to her initial application month. Her income has not changed but her AG has increased and her spend down is now $150 for this first review. She may use $150 from the $700 that is still owed. She is approved for another year and has $550 of the same bill remaining which may be used at the next redetermination if it is still owed, is not written off by the provider and she meets the requirements for MN Medicaid.

This same spend down policy applies to pregnant women and children who are not currently receiving Medically Needy Medicaid.

- Any amount remaining from the incurred expense may be carried forward to be used for the next redetermination, if the expense is still owed.
- Any amount left over after the first redetermination may be carried over to be used for the second redetermination, if the expense is still owed.
- After the first year of eligibility, acceptable expenses will be limited to those incurred during the new application month and the three months prior to the new application month plus any unpaid medical expenses that were previously verified and documented as part of this new spend down process. The verified bills may continue to be carried over as long as the individual remains continuously spend down eligible; the bills remain unpaid, and are not written off by the provider.

If the individual has income under the Medically Needy income standard (exceptionally eligible) at the redetermination, the balance of the previously used incurred expense will no longer be carried forward for use. If the individual loses eligibility at any time, or if he ever qualifies as Exceptionally Eligible, the carryover ends.

When an Exceptionally Eligible individual reapplies, no bills may be carried over because he/she did not have to meet spend down to qualify. He/she will be required to meet the "new applicant" criteria listed above.

If the balance of the incurred medical expense is insufficient to meet the spend down at redetermination, the balance will no longer be carried forward for use.
Continuous MN eligible individuals must have the following at redetermination to establish continued eligibility:

- Bills incurred during the month of application (whether paid or unpaid);
- Bills paid during the month of application (regardless of when the bill was incurred);
- Bills incurred during the three months prior to the month of application (whether paid or unpaid); and
- Unpaid medical bills incurred during the application month or three months prior to the application month during the continuous MN eligibility period may include expenses not paid by TennCare as covered expenses.

Refer to the Chapter on Treatment of Income and Budgeting for complete policy and procedures for establishing eligibility in the Spend Down Program.

Application Processing

Application Processing Time Limit; Legal Base: 42 CFR 435.211

Federal regulations require that a decision regarding MN eligibility be made and notification of that decision be mailed to the applicant within 45 days from the date the DHS office receives the signed application.

A separate application is not required to pursue eligibility for the MN category if an application is denied or the FF or any other category of TennCare Medicaid is closed. Conduct an exparte review for MN based on the information in the case file, if possible. If additional information is needed, a verification request form is used with the usual 10-day timeframe for receipt of needed information.

Applications by Minors

An individual must be at least 14 years of age to apply for MN as a caretaker. A minor parent who requests medical assistance for his/her child may be included in the budget group (and the aid group) as the caretaker of his/her child or in a group with his/her parent(s) as a child.

Parents retain financial and legal responsibility for a child until the child reaches his majority or is married. Therefore, their (the parent(s)') resources and income are considered available to their unemancipated minor child who is a parent with an established MN case as the caretaker of a child under age 21. If the minor parent is included as a child in his/her parent(s)' case, the parent's resources and income are deemed available to the minor parent. At all times, only the minor parent's individually owned income/resources are deemed available to his/her own child.

- Emancipation

  Marriage emancipates a minor from parental authority and responsibility but does not remove his/her minority. Divorce during the child's minority does not restore parental financial responsibility. An annulment, however, during a child's minority does remove his/her emancipated state if he/she returns to live with his/her parents.

  A minor who is or has been married can be included in a MN group as an eligible child. A minor, at least 14 years of age, is considered emancipated if his parents are deceased or their whereabouts are unknown.

  A minor, at least age 14, is considered emancipated if he/she lives outside the parents' home and the parents claim no responsibility for him, i.e., provide no financial support and/or do not claim him as a dependent for income tax purposes.

  A minor age 14 may be emancipated under any of three conditions described above, but by general law, is not considered capable of handling the responsibilities attendant to TennCare Medicaid eligibility. Name a payee, who is at least 18 years of age, to receive the TennCare card in behalf of the minor and the children in his/her care. Make a referral to the Department of Children's Services for homeless children and children under 18 who live alone in an identifiable arrangement.

Authorization of TennCare Medicaid benefits

Eligibility begins the date of application or the date eligibility is met, whichever is later.

Include the needs of an unborn technically/financially eligible child to an already established budget group effective the date the verification of the pregnancy is provided.

Annual Review

Eligibility reviews for all Medicaid categories are due 12 months following the month of approval or the month of the last eligibility re-determination. The data base will automatically set the 12-month certification on the authorization screen if the Medicaid group is the only open aid group on the case or when all other open aid groups allow a 12-month certification period per policy.

EXAMPLE: If an open exceptionally eligible MN case has no associated Food Stamp group, the data base will set the review date on the authorization screen for 12 months in the future. However, if there is an open Food Stamp or Families First group in the case, the review date should be set as determined by policy.

If the client fails to complete a Food Stamp recertification, this must not affect Medicaid eligibility if it is not time for the annual review.

Closures

Eligible children and caretakers in the MA T coverage group receive an additional 12 months of TennCare coverage following the end date shown on the data base. This extension is assigned by the Bureau of TennCare and is reflected in the Eligibility Screen on the TennCare Interchange system.

Individuals whose TennCare Medicaid is ending must be processed through an Ex-Parte Review. Refer to the Chapter on the Medicaid Extend for further details on closure processing.

INSTITUTIONALIZED AND HOME AND COMMUNITY BASED SERVICES ELIGIBILITY

Policy Statement

An individual who enters one of the Long Term Care Facilities (LTCF) or is enrolled in one of the Home and Community Based Services (HCBS) Waiver programs licensed and certified by the Bureau of TennCare may be eligible to have his/her care in the LTCF or HCBS paid by TennCare Medicaid funds. These payments, called TennCare Medicaid Vendor Payments, are handled by the Bureau of TennCare's fiscal agent in addition to other TennCare Medicaid reimbursements.

DHS caseworkers determine the individual's eligibility for TennCare Medicaid by applying the regulations cited in this Manual. DHS caseworkers also determine the recipient's patient liability amount which authorizes the fiscal agent to make vendor payments to the LTCF or the HCBS lead agency upon authorization of a Pre-Admission Evaluation (PAE) by the TennCare Bureau. In addition, DHS caseworkers authorize TennCare Medicaid vendor payments for the Supplemental Security Income (SSI) recipients who enter the LTCF or the HCBS, although DHS does not determine TennCare Medicaid eligibility for these individuals.

The Home and Community Based Services (HCBS) waiver is available for individuals who meet all the requirements for nursing home eligibility but prefer to stay in their homes. Individuals served by this waiver must have an approved Pre-Admission Evaluation (PAE) through the Bureau of TennCare and have their financial eligibility determined by DHS. Following is a description of each HCBS waiver, where they are available, and the services each one provides.

HCBS Contract Agencies

TennCare Medicaid Services are available to individuals who meet all the requirements for long-term care services but prefer to stay in their home. Currently Tennessee provides Medicaid services to individuals enrolled in the four HCBS waivers defined below and a model waiver for the Mentally Retarded.

HCBS-ED Waiver Fact Sheet

The Elderly and Disabled in Tennessee have a choice for long-term care services, which include a Nursing Home or one of four Home and Community Based Services (HCBS) Programs. The HCBS programs are:

- Shelby Co. Waiver provides services for the elderly and disabled in *Shelby County* only.
- ADAPT Waiver provides services for the elderly and disabled who live in *Davidson, Hamilton or Knox Counties* only.
- Statewide Waiver provides services for the elderly and disabled anywhere in the state.

Enrollees in the Shelby, ADAPT and Statewide Programs must:

- be at least 21 years of age
- meet criteria for Level 1 nursing home care
- meet the financial criteria

Contact numbers:

Shelby Co – Senior Services - 901-766-0600

ADAPT – Senior Services
Davidson Co. – 615-837-0700
Knox Co. - 865-769-8007
Hamilton Co. -- 423-894-4322

Statewide Waiver –The Area Agencies on Aging - 866-836-6678

PACE Program (Program of All-inclusive Care for the Elderly) *Hamilton County* only. Enrollees in the PACE program must:

- be 55 years or older,
- meet criteria for Level 1 nursing home care
- meet the financial criteria.

Contact number:

PACE program – 423-495-9100

Below are the services that each program provides.

		PACE	State Wide	Shelby Co.	ADAPT
Case Management		?	?	?	?
Personal Care		?	?	?	?
Minor Home Modifications		?	?	?	?
Personal Emergency Response (PERS)		?	?	?	?
Home Delivered Meals		?	?	?	?
Homemaker		?	?	?	
Respite		?	?		

The **PACE** program also provides an adult day care center and covers all medical needs of the enrollee, including but not limited to hospitalization and nursing home Coverage. **Individuals enrolled in PACE are not subject to a patient liability**

Statewide MR Waiver Program

The waiver for individuals with mental retardation or developmental disabilities (#0128.90.R2A), as revised January 1, 2005, provides community-based services to individuals with mental retardation or developmental disabilities who would otherwise require the lever of care provided in Intermediate Care Facility (ICF/MR).

The Division of Mental Retardation Services (DMRS) in Tennessee Department of Finance and Administration serves as the Operation Administrative Agency for this waiver, which is administered under the supervision of the Bureau of TennCare.

To enroll in this HCBS waiver program, you must

- Live in Tennessee
- Be financially eligible for Medicaid;
- Meet TennCare criteria for payment of institutional ICF/MR care; and
- Have an adequate support system to assure health and safety while receiving services in a home and community based setting.

For individuals wishing to enroll or simply to find out more about this waiver you may contact any of the following numbers:

Division of Mental Retardation Services (DMRS)
15th Floor Andrew Jackson Building
500 Deaderick St.
Nashville, TN. 37243
615-532-6530

800-535-9725
Fax # 615-532-9940
www.state.tn.us/dmrs

Regional Offices		Developmental Centers	
Memphis	901-213-1800 800-654-4839	Arlington	901-745-7200
Jackson	731-423-5670	Clover Bottom	615-231-5000
Nashville	615-231-5049 800-654-4839	Greene Valley	423-787-6800
Knoxville	865-588-0508 888-654-4839		
Greenville	423-434-6530		
Johnson City	423-434-6530		

If you qualify for care in an ICF/MR, you will have the right to choose between care in the home or institutional ICF/MR care. If you choose to receive HCBS waiver program services in the home, you will still be eligible to receive the follow services if needed:

- Adult Dental Services
- Behavioral Respite Services
- Day Services
- Environmental Accessibility Modifications
- Family Model Residential Support
- Individual Transportation Services
- Medical Residential Services
- Nursing Services
- Occupational Therapy Services
- Personal Assistance
- Personal Emergency Response Systems
- Physical Therapy Services
- Residential Habilitation
- Respite
- Specialized Medical Equipment
- Speech, Language and Hearing Services
- Support Coordination
- Supported Living
- Vehicle Accessibility Modifications

TennCare Medicaid services are also available to individuals who meet all the requirements for institutionalized long-term care.

Types of Long-Term Care Facilities Qualifying for TennCare Medicaid Vendor Payments

TennCare Medicaid vendor payments are available to eligible patients receiving long-term medical care in certain long-term medical institutions as specified below:

- State Developmental Centers for the Mentally Retarded including Certified (i.e. TennCare Medicaid approved) ICF-MR wards for patients of any age and Certified Level II nursing wards for patients of any age. Patients in non-certified wards in Level II care are not eligible for TennCare Medicaid except when transferred to a Title XIX (TennCare Medicaid approved) facility.

- State Mental Health Hospitals and Private Certified Mental Health Hospitals including general hospital wards for patients age 65 and older and Certified Level I and Level II wards for patients age 65 and older. Patients in non-certified wards and all patients under age 65 are not eligible for TennCare Medicaid in psychiatric facilities with the following three exceptions:

    - A patient who was already an active TennCare Medicaid recipient when admitted to the psychiatric facility will be eligible the month of admission (no vendor payment can be authorized by DHS). Coverage cannot extend beyond the month of admission or the month earliest action to close the case can be taken.

    - Ineligible patients who are transferred to a Title XIX (Medicaid-TennCare approved) facility located off the hospital grounds may retain eligibility during their absence from the facility.

    - Patients under age 21 may be eligible for TennCare Medicaid if they are receiving active in-patient treatment in an accredited psychiatric hospital. These cases are not defined as long-term institutional cases, as no vendor payment is made.

- Licensed Public and Private Nursing Homes including Level I, Intermediate Care Facility (ICF), for patients of any age and Level II, Skilled Nursing Facility (SNF), for patients of any age.

- Tuberculosis Care Units for patients age 65 and older are eligible for vendor payments; however, Tennessee does not have any chest disease/TB hospitals or care units. Coverage is limited to Tennessee residents at least age 65 whose out-of-state care has the approval of the Bureau of TennCare.

NOTE: Residents of unlicensed nursing homes or custodial homes are not considered to be receiving medical care and therefore do not meet the medical institutionalization technical requirement. Accordingly, these individuals are ineligible for vendor payments. Also, they are ineligible for TennCare Medicaid as institutionalized individuals.

- Certified Institutions are long-term care facilities certified by the Bureau of TennCare and have a TennCare Medicaid per diem rate established by the State Comptroller's Office. A list of certified facilities and their rates is furnished to each county DHS office by the Comptroller's office. A list is also available at the Department of Health's website which can be accessed at http://www2.state.tn.us/health/HCF/Facilities_Listings/facilities.htm. If a DHS caseworker receives a request for TennCare Medicaid reimbursement from a facility not included in this list, contact the State Office TennCare Medicaid Policy Unit for information regarding the facility's certification status.

Responsibilities of the Bureau of TennCare

In addition to oversight and monitoring, the Bureau has additional responsibilities where long-term care or HCBS is involved. The TennCare Bureau contracts with licensed and certified long-term care medical institutions such as Level I and Level II nursing facilities as medical providers under the Medicaid program. The facility agrees to accept reimbursement from TennCare Medicaid funds for the TennCare Medicaid eligible patients in their care. Facilities that elect not to contract are referred to as non-participating facilities and their patients may not claim TennCare Medicaid reimbursement for their care. The Bureau of TennCare determines the patient's need for care and the level of care he requires in the following ways:

- A physician examines the individual and completes a Pre-Admission Evaluation (PAE). The Bureau of TennCare's PAE Unit evaluates the PAE to determine if the individual meets the requirements set by Federal Regulations for a specified level of nursing care. The levels of care include the following:

    - Level I (ICF) care is nursing care of a greater level than room and board but less than the degree of care and treatment provided in skilled care.

    - Level II (SNF) care is a level of nursing care above Level I care and below hospital care. It is sometimes referred to as extended care and is the only level of long-term care that is reimbursed by the Medicare program.

- The individual's need for care at Level II is approved through the Medicare program, and the determination is accepted by the Bureau of TennCare. When Medicare ceases payment, a PAE is required.

- State and private psychiatric facilities may have beds in a general hospital ward in addition to their Level I and/or Level II care beds. These facilities are routinely audited by the Bureau and patients admitted to the hospital care ward do not require a PAE as part of the vendor eligibility criteria.

Responsibilities of the Long Term Care Facility and/Or HCBS Contract Agency

The long-term care facility and/or HCBS Lead Agency also bear certain responsibilities under the terms of its contract with the Bureau of TennCare.

The facility reports the admission and discharge of its TennCare Medicaid eligible patients (and applicants) including SSI recipients in writing via Form 2350, Notice Recipient-Patient Was Admitted To or Discharged from Skilled Nursing Home Care or Intermediate Care, to DHS. The Admission 2350 will include:

- The name, social security number and date of birth for the patient
- The date of admission to the facility, i.e. the first date the facility will accept TennCare Medicaid reimbursement for the individual's care.
- The name and address of the responsible party.
- The amount and source of the individual's income.
- The PAE effective date for long-term care cases, if known.
- The last full day of Medicare reimbursement for the Level II care patient, if applicable.
- The PAE effective date must be included on HCBS cases to verify enrollment in the waiver program.
- The name and address of the medical facility from which the client was discharged, if applicable.
- The level of care to which the individual is admitted.

The Discharge 2350 reports the level of care, the individual's forwarding address and the date the individual is officially discharged from the facility due to one of the following:

- Discharged to home
- Transferred to another facility
- Expiration of the bed-hold
- Therapeutic leave expiration
- The individual's death including the last day of care and the date of death.

For Expedited PAE Processing- (expedited processing is available for all HCBS programs except PACE and MR waiver). The Contract Agency must identify potential enrollees prepare and submit a PAE and Presumptive Eligibility (PE) form to TennCare Division of Long Term Care for processing. The PE form will contain at minimum demographic information of income and resources.

The Contract Agency must:

- Provide a DHS application for the client to complete and return to the local DHS office.

- Submit a PAE application and TennCare will process PAE in eight (8) days or less. If approve, TennCare will notify the client and fax the contract agency and DHS district designee the PE form and PAE approval validation.

- Submit a Notice of Admission form 2350 to the Department of Human Service on the same day they receive an approved PAE form the Bureau of TennCare Long Term Care Division.

- Conduct a plan of care with reviews at least every 90 days.

The Pre-Admission Evaluation (PAE) Process

The facility to which the individual is confined or the HCBS Lead Agency must be an approved and participating provider which has accepted the individual as a TennCare Medicaid patient and has sent a completed Form 2350 (HS-0244) to the local DHS office. A PAE is required as part of the enrollment process in HCBS cases. An individual cannot be entered into HCBS without an approved PAE. **A PAE approval date is not required prior to approval for TennCare Medicaid in either Level I or Level II or certified psychiatric facilities, but a PAE approval date is required prior to authorization of vendor payments.**

If the PAE approval date **has not been reported**, only pregnant adults and children under age 21 are potentially eligible for TennCare Medicaid benefits.

If the PAE approval date has been reported, use the PAE date or TennCare Medicaid eligible date, if later, as the vendor payment approval date. The LTCF or the Lead Agency (LA) for HCBS assists the individual in obtaining and properly submitting the pre-admission evaluation if he does not have one upon admission. Any future re-evaluations required after admission are the responsibility of the facility/LA. If a PAE is not initially approved, an appeal process exists and is handled by TennCare.

A valid PAE is one that has been approved within 90 days of the individual's admission to the LTCF and has not been used previously by the individual at another LTCF. The facility will report any unapproved PAE's to DHS by 2350 or by telephone. Written verification is not required of these PAE's.

An approved PAE is required prior to vendor payments being made. An explanation must be given to the applicant or his/her responsible party that TennCare Medicaid will not pay the LTCF or HCBS for nursing services unless there is an approved PAE for the period coverage is requested.

A copy of the PAE form may be viewed on the TennCare website at www.state.tn.us/tenncare/PAE_form.pdf.

To expedite service delivery for the HCBS program, the TennCare Bureau has initiated a Presumptive Eligibility (PE) process which allows contract agencies to identify individuals who

may qualify for an HCBS waiver to receive services as soon as the PAE is approved. The PAE process should be completed within 8 days of the PAE application reaching the TennCare Bureau.

PE is available to all HCBS enrollees except those individuals enrolled in PACE and DMRS waivers. The PE coverage will begin prior to DHS determining on-going eligibility. PE is offered only to the HCBS population and not to the nursing home population. PE would be for a 45 day time period and if an application for Medicaid (HS-1069) has not been filed at DHS within the 45 days or a DHS decision has not been reached within the 45 days PE period, the PE coverage will end. HCBS services only are covered during the PE period.

Responsibilities of the Department of Human Services

If a 2350 is received from a LTCF/LA regarding an individual who is not currently eligible or has not filed an application, take the following steps:

- Immediately mail an application form (HS-1069) to the individual/responsible party involved explaining the need for an application if TennCare Medicaid coverage is requested to pay for LTC services. A copy of the letter must be provided to the nursing home.

- Include the date you expect the form returned—10 days from the application mailing date. If no response is received from the individual/responsible party within that time frame, mail another application form and letter marked "FINAL NOTICE" to each of the same parties. Include the date you expect the form returned—5 working days from the actual mailing date. If no response is received from the individual/responsible party within that time frame, retain the 2350 with copies of all correspondence in a file for 12 months. If an application is received for individual during that 12-month time, determine eligibility as usual.

- If the form is returned as requested determine initial and continuing eligibility for TennCare Medicaid coverage and vendor payments. Coverage and vendor may begin the date of application or the date an individual is otherwise eligible.

- Authorize disposition of the application on ACCENT.

- Complete form 2362 (HS-0245) when necessary to manually update or correct Bureau of TennCare files regarding patient liability**; however, form 2362 should ONLY be completed for specific reasons which are listed below.** If the individual is in an active data base case the month of admission, a 2362 must be completed for that month and any subsequent months until the change in living arrangements and eligibility can be completed on the computer data base.

  A copy of the 2362 is routed to the individual, responsible party, nursing home, Lead Agency, and if applicable, fiscal agent at the Bureau of TennCare (Renelda M. Boyd, Operations Support Supervisor EDS/TennCare, 310 Great Circle Rd. Nashville, TN. 37202-1700). An additional copy is required for the Department of Mental Health and

Developmental Disabilities (DMHDD); Fiscal Services for the HCBS Adult/Children's Waiver. The DMHDD copy should be mailed to:

Department of Mental Health and Developmental Disabilities
Fiscal Services for HCBS Adult/Children Waiver Program
425 Fifth Avenue North
Nashville, TN. 37243

- For HCBS Expedited Processing for new applicants in certain waiver programs when an individual is not currently Medicaid active – DHS will mail an application to the Responsible Party (RP) upon receipt of the 2350. DHS will process the application in accordance to the requirements set forth by DHS State Rules.

- DHS county office is divided into eight districts throughout the State. DHS has designated one staff person for each of the eight districts to receive the Presumptive Eligibility Forms and applications for the HCBS waiver program. This staff person will monitor the application for expedited completion and serve as a contact for the lead agency personnel.

Although case disposition must be expedited, in no instance should approval be processed prior to the 30th day from PAE approval begin date except in situations involving HCBS enrollment. An HCBS enrollee can be determined to need and to be likely to receive services for a continuous period of at least 30 days going forward. Case approval must be processed prior to the 30th day from PAE approval so long as all other Medicaid eligibility requirements have been met.

DHS will interview the RP in order to gather technical eligibility and financial information of the patient and spouse.

If currently SSI cash eligible, the Eligibility Worker will submit the 2362 form to the customer, the lead agency and the Medicaid Fiscal agent. Since they already have Medicaid no PE is needed for SSI cash eligible.

General Eligibility Criteria for Vendor Payments

Institutionalization is based on continuous confinement to a medical facility/facilities or HCBS program for at least 30 consecutive days or for individuals applying to enroll in HCBS, the individual is determined to need and to be likely to receive services for a continuous period of at least 30 days going forward. Hospital stays prior to or during confinement in the nursing facility or HCBS are counted also if confinement was continuous between both facilities and HCBS; however, vendor payment eligibility is not authorized to begin prior to the admission to the LTCF or HCBS. Continuous confinement is also met if the individual dies prior to 30 days in the LTCF/HCBS. To be eligible for TennCare Medicaid vendor payments in a long-term care facility or a HCBS, the individual must fulfill several technical and financial criteria.

The eligible member of any of the following coverage groups is technically and financially eligible for TennCare Medicaid:

- The individual meeting continuous confinement requirements in a LTCF or is determined to need and to be likely to receive services for a continuous period of at least 30 days going forward in HCBS and whose gross income is less than the Medicaid Income Cap.
- The individual who would be eligible for Families First except for institutionalization in a LTCF/HCBS**. NOTE**: Requirements for persons who would be eligible for FF are located at the end of this chapter.
- Recipients of Supplemental Security Income (SSI)
- Recipients of Families First
- Medicaid Only individuals who are "grandfathered-in" recipients of Old Age Assistance, Aid to the Blind, or Aid to the Disabled prior to the SSI program.
- SSI Pass Along and Pickle - These individuals are eligible the month of admission to a LTCF and if necessary one additional month to effect closure of the Pass Along case and open a case in the institutionalized category.

Determining Financial Eligibility for Vendor Payments

Categorical eligibility for the month of admission and subsequent months based on continuous confinement in a LTCF or is determined to need and to be likely to receive services for a continuous period of at least 30 days going forward in HCBS is determined by comparing the individual's gross income to the Medicaid Income Cap is determined by comparing the individual's gross income to the Medicaid Income Cap (MIC). The MIC is equal to 300% of the full SSI-FBR for an individual. If the gross income is equal to or less than the MIC, vendor payment eligibility is determined.

Qualified Income Trust (QIT), when an individual's pension or social security income and other monthly income is placed in a QIT for the purpose of establishing income eligibility for Medicaid when confined to a nursing facility or HCBS waiver program.

Medically Needy eligibility is potentially available for pregnant women and children under age 21 **only**.

Active TennCare Medicaid recipients confined for less than 30 days have no financial or resource test if confined to a LTCF for less than 30 consecutive days when the individual is a recipient of SSI, FF, or Medicaid Only benefits. The individual is already eligible for TennCare Medicaid for that month and is to be accorded any and/or all of the services covered by TennCare Medicaid eligibility. The vendor payment for LTCF will depend on approval of the PAE by the Bureau of TennCare. The individual's patient liability will be zero $0.

Procedures to Determine Eligibility for TennCare Medicaid and Vendor Payments/Patient Liability

Determine the individual's gross income and compare it to the Medicaid Income Cap (MIC) which is 300% of the SSI/FBR. If the individual's income is equal to or less than the MIC, the patient is categorically eligible for Medicaid.

- Verify that the individual is confined to the LTCF by means of the 2350 from the LTCF for 30 days of continuous confinement. The Lead Agency will provide 2350 for HCBS

enrollees who have been determined to need and to be likely to receive services for a continuous period of at least 30 days going forward.

- Verify that the individual's resources are below the resource limit as outlined in the resource section of this manual.

- If the individual's income is more than the MIC, check to see if he/she has established a Qualified Income Trust (QIT). A QIT allows an individual to place all or part of his/her monthly income in an income trust and the income that is placed in an income trust is excluded from the gross income test.

- Calculate the amount of the individual's patient liability by making deductions in the order listed:

    - Subtract the Personal Needs Allowance (PNA) from the gross income which is $40 for an individual in a nursing facility and 200% of the SSI/FBR for HCBS.

    - Subtract the $20 bank fee for individuals who established a QIT for Medicaid eligibility purposes.

    - Subtract the appropriate Spousal Impoverishment Allocation for spousal/dependent allocation.

    - Subtract medical/health insurance premiums.

    - Subtract any non-covered medical expenses recognized as a medical expense by state law but not covered by TennCare Medicaid.

    - The result is the individual's patient liability.

Vendor Eligibility for SSI Recipient(s)

Individuals requiring only temporary institutionalization as recommended by a medical doctor may receive up to the full FBR for home maintenance for up to three months. The SSI payment amount (i.e. the amount received by the patient) is disregarded and other allowable deductions are made in determining patient liability during those three months.

- Individuals May Continue to Receive SSI Cash Payment For 2 Or 3 Months After The Social Security Office Receives the 2350

  If an institutionalized individual was receiving SSI only, Social Security will reduce the monthly payment to $30. Authorize vendor payments using SSI Medicaid Identification Number. Email David Erwin (DE93MEF) to assist in expediting the cash reduction.

- Individuals Who Receive SSI Along With Other Income That Is More Than $50

  Do not count the SSI cash payment in determining patient liability cases when the individual receives SSI benefits along with other income that is more than $50.

- Individuals Who Receive SSI Along With Other Income That Is Less Than $50.

  Count the actual SSI payment that the individual will receive in determining patient liability. When an individual receives SSI along with other income that is less than $50, Social Security will disregard $20 of the other income and the individual will remain eligible for an SSI payment. However, the individual's total income including SSI will not exceed $50.

  EXAMPLE: Mrs. Walmart is admitted to a LTCF and on the day of admission, her income totaled $484 SSI and $30 pension. Social Security will reduce her income to or below the LTC SSI/FBR ($30).

SSI Budgeting Process Used To Arrive At the $30 SSI/FBR

Pension		$30	Adjusted Pension		$10
Disregard	-	20	Total SSI payment	+	20
Adjusted Pension		10	SSI/FBR		30

DHS Counts the SSI Payment Amount in Determining Patient Liability

Pension	$30	Countable Income		$50
SSI payment	20	PNA	-	30
Total countable income	50	Patient Liability		20

Check SOLQ in 30 days for payment status. If an institutionalized individual was receiving both SSA and SSI prior to becoming institutionalized, Social Security will stop the SSI payment. The pay status code displayed in SOLQ will be changed to 'E01'. If the SSI reflects a reduction to $30, the pay status code will remain 'C01'.

Enrollment in Home and Community Based Services (HCBS) Waivers for Individuals Who receive SSI Cash

SSI cash recipients are Medicaid eligible and are not required to file an application for Medicaid with DHS or to provide verification of income, including income other than SSI or SSA, since such income has already been reported to and verified by the Social Security Administration

Effective June 1, 2008; to begin enrollment in an HCBS waiver, the local Area Agency on Aging and Disability (AAAD) or the Department of Mental Retardation Services (DMRS) Regional Office, as applicable, will fax the DHS form 2350, 'Notice Recipient-Patient Admitted to or Discharged from Skilled Nursing Home Care or Intermediate Care' to the DHS Medicaid Policy

Unit in State Office. The form will be faxed to the attention of Dominic Itto, Program Specialist at (fax # 615-313-6639).

Upon receipt, the form will be immediately processed following the steps outlined as follows:

- Use the enrollee's Social Security number to check State On-Line Query (SOLQ) for SSI cash eligibility and to obtain income information, including income other than SSI or SSA, as reported to and verified by SSA. Further verification of income by DHS is not required.
- If the enrollee is SSI cash eligible, DHS form 2362, 'Notice of Disposition or Change (for Skilled Nursing Care and Intermediate Care Facilities) will be completed and faxed to the AAAD or the DMRS Regional office, as applicable, **and** to the HCBS Unit (fax # 615-532-9140), located in the TennCare Division of Long Term Care.
- The HCBS Unit, (Bureau of TennCare) will monitor the 2362 to ensure it is processed by the Bureau of TennCare's fiscal agent.
- Dominic Itto, in the DHS Medicaid Policy Unit will check the TennCare InterChange system in one week to ensure the patient liability segment is showing on InterChange.
- A paper file of HCBS SSI cash eligible individuals will be maintained in the Medicaid Policy unit in State office.
- If the enrollee is not SSI cash eligible, Dominic Itto will notify the AAAD or DMRS Regional Office, as applicable, and route the 2350 to the appropriate DHS district contact responsible for processing HCBS enrollment requests. HCBS applicants who are <u>not</u> SSI cash eligible must qualify in the institutional/HCBS eligibility category in order to qualify for enrollment in HCBS.

The AAAD or DMRS representative will act as a contact with the applicant/enrollee and his/her family or other authorized representative(s) and will remind them of their obligation to report any changes in income to SSA (in order to ensure continuing eligibility for SSI cash payments) and to DHS within 10 days (for purposes of recalculating patient liability). In conducting annual reviews of income and resources eligibility for SSI cash recipients (and in reviewing/updating patient liability as appropriate), DHS will rely on resource eligibility as determined by SSA and income information in SOLQ as reported to and verified by SSA. A new application or further verification of resource and income eligibility by DHS is not required.

<u>NOTE: The 2350 is only an enrollment form for institutional services or HCBS waiver programs. If the HCBS enrollee requests food stamps, the AAAD or DMRS representative will advise the enrollee to file an application at the local DHS county office.</u>

<u>The SSI Pass Along/Pickle Case Admitted to Long Term Care</u>

- An individual eligible as a SSI Pass Along/Pickle does not remain eligible as a member of the coverage group upon admission and 30 days continuous confinement to long-term nursing care.

- SSI Pass Along and Pickle cases are TennCare Medicaid eligible as long as their income minus all appropriate SSA cost-of-living adjustments is less than the current SSI-FBR for

- their living arrangement. Upon admission to long-term care (i.e. nursing home, not a hospital), the SSI-FBR is reduced to $30, and these individuals automatically become ineligible due to the amount of their income. Follow these steps when an individual eligible as a SSI Pass Along or Pickle is admitted to a long-term care facility.

- Form 2350 will be received from the admitting facility showing the individual has been admitted to long term care OR the client or his authorized representative will reports his admission.

- The individual will be TennCare Medicaid eligible for the month of admission to the LTCF/HCBS as he/she is already eligible for TennCare Medicaid for that month as a Pass Along/Pickle case. Complete the aid group closure procedures. If Pass Along/Pickle eligibility must be extended for an additional month to allow adequate and timely notification of case closure, the individual may continue to be eligible as a Pass Along/Pickle for that two months only

- Calculate the patient liability off-line complete a manual Form 2362 and route as instructed above.

- Determine continuing eligibility for TennCare Medicaid and vendor payment/patient liability as for all other institutionalized individuals. Determine if the individual remains TennCare Medicaid eligible, but as an institutionalized individual rather than a Pass Along or Pickle, by comparing his gross countable income to the MIC. If the individual has income equal to or less than the MIC, he remains TennCare Medicaid eligible. Determine the amount of his patient liability and authorize TennCare Medicaid vendor payments.

- If the individual's income is over the MIC, explain policy as regards to the Qualified Trust.

Authorization Procedures

Authorize TennCare Medicaid eligibility and vendor payments the later of the following:

- The date the signed application was received at DHS, or

- The date the PAE was approved, or

- The date the individual meets 30 days continuous confinement in a nursing facility, or

- The date individuals enrolled in a Home and Community Based Services (HCBS) waiver program have been determined to need and to be likely to receive services for a continuous period of at least 30 days going forward.

TennCare Medicaid vendor payments end the earlier of:

- The date of discharge, OR

- The date of death, OR

- The last day of a month if the individual/couple will be ineligible for the following month (vendor payments by the TennCare Medicaid Bureau will actually end with discharge date).

The Notice of Disposition is used to report patient liability amounts to the client and/or the authorized representative/responsible party. The DHS caseworker must print a copy of the off-line budget sheet and mail it to the LTCF or LA as validation of the patient liability information. The off-line budget sheet copy is also mailed to the DHMDD Fiscal Services and Office of Community Services for certain HCBS cases. This authorizes payment for TennCare Medicaid and provides the patient liability amount.

Authorization Using Form 2362 (HS-0245)

Form 2362, Notice of Disposition or Change (for Skilled Nursing Care and Intermediate Care Facilities) is used to notify the individual confined to long term care and/or his responsible party of a change in patient liability. The form is completed manually and there are limitations on when it can be used.

NOTE: Please do not submit a 2362 when the patient liability is zero before the budget change and will remain zero after the budget change (i.e. COLA in SSI only cases). Do not submit a 2362 when a patient transfers from one nursing home to another nursing home. Reporting requirements for the move is the responsibility of the receiving nursing home.

Form 2362 may be submitted:

- **When the begin date of eligibility is so far in the past that ACCENT cannot create a budget.** ACCENT is capable of creating budgets at least five months prior to the current date. If a manual 2362 is needed because ACCENT cannot create a needed patient liability month, remember that the 2362 is only for changes in the patient liability information. If the Medicaid eligibility segment on InterChange needs to be changed, this change request must be made to the TennCare Medicaid policy unit in the DHS state office.

- **When the patient's only income is SSI**. When a patient enters the nursing home and the only income is from SSI, vendor payment must be authorized using a Form 2362. A 2362 is also needed when the patient is discharged.

- **When there is a patient liability overcharge**. When a patient has paid more toward his cost of care than he was liable, do not submit a 2362 to decrease patient liability in the same month, Rather, deduct the overcharge prospectively (going forward) to avoid submitting a 2362 unless it is in the month of death or discharge. If there has not been a final accounting of all expenses in the month of death and discharge, complete a 2362 for past retro month.

- **When an individual is in the nursing home for a short period of time and is eligible for Qualified Medicare Benefits (QMB).** When an individual has been admitted to a nursing home for a short period of time and is eligible for QMB, but is not TennCare Medicaid eligible, he/she may be eligible for long term care co-pays under QMB. Check to see if Medicare paid a percentage of the nursing home charge. If Medicare paid a percentage of the nursing home charge, using a 2362, authorize the 20% co-pay. Write "QMB ONLY" across the top of the 2362.

- **When an individual is eligible for other TennCare Medicaid categories and has been confined for less than 30 days**. A 2362 may be used to authorize payment to the nursing home when an individual is confined for less than 30 days and is eligible for TennCare Medicaid in other categories, such as MA C, MA S, MA T, or MA K.

Form 2362 is manually distributed as follows:

- The client
- The authorized representative
- The LTCF or LA
- The Medicaid Fiscal Agent
- The DMRS Fiscal Services and Office of Community Services (only for HCBS cases handled by DMRS caseworkers)

The comments screens in the computer data base must be adequately documented regarding the Form 2362 completion and submission when there is a case on the computer system.

Patient Liability Changes

Monthly deadlines for submitting patient liability changes on active cases (i.e., for individuals already authorized vendor payments) have been established. Any increase in the amount of the patient liability requires client notification of 10 days prior to the effective date. A decrease in the amount of the patient's liability does not require notification 10 days prior to the effective date, though an explanation of the reduction is required.

Any change in the amount of the patient liability with an effective date in a prior or current month is prohibited UNLESS:

- To recalculate patient liability for the last month of institutionalization due to death/discharge and there are additional Item D's to be considered, or

- A correction is being made in a patient liability overcharge due to an agency error (corrections may be made up to the past 24 months).

  An agency error means a mistake made by the DHS caseworker, e.g., an arithmetical mistake or failure to act promptly regarding a reported change that resulted in an overstated liability or overdue eligibility review. It does not include errors made that are the result of the failure of the client, the authorized representative, or the LTC provider to report

changes within 10 days of their occurrence, or any error that is not directly attributable to the caseworker, such as Item D's which cannot be deducted in full for the last month of institutionalization because expense exceeds income.

- Effective June 1, 2007, vendor payments may no longer be authorized retroactively for a newly approved case.

  Vendor payments may be no longer be authorized retroactively.

A patient liability overcharge that occurred in a prior month can be adjusted in a future month(s) IF the overcharge was the result of an agency error or administrative procedures. The correction may also be adjusted retroactively, if necessary. A patient liability overcharge results when the client pays more toward the cost of his/her care than he/she should have, or when the individual's Item D deductions are greater than his/her countable income.

Adjust the overstated liability as soon as possible after it is discovered. Confine the adjustment to one month if at all possible, even though it may reduce the patient liability to zero. An adjustment may continue more than one month if necessary to fully reimburse the client. Explicitly label the Form 2362 as a "Correction" for retroactive corrections or enter as a patient liability overcharge on the appropriate ACCENT budget screen. Immediately terminate the adjustment effective the month following the adjustment month (or later, if necessary). Notice must be given at least 10 days before the effective date of the increase in patient liability.

Due to the confusion on when patient liability may be retroactively changed, and because of the difficulty in correcting a 2362 information, all handwritten 2362 forms should be routed to the Bureau of TennCare, Long Term Care Division by mail or fax. DO NOT send the screen from the computer system. The address is:

Long Term Care Division
Bureau of TennCare
310 Great Circle Rd.
Nashville, TN 37243
Fax: 615-741-0882

If it is not possible to fully adjust an overstated liability for some reason, e.g. the client's financial situation changes or the case is closed, there is no mechanism for the client's recoupment of any overstated patient liability other than through retroactive correction of the overcharge using Form 2362. The Form 2362 must clearly indicate "Correction" at the upper portion of the form and may contain corrections for up to the previous 24 months from the current processing month.

WHO WOULD BE ELIGIBLE FOR FAMILIES FIRST

Policy Statement

Legal Base: 42 CFR 435.211

One of the coverage groups eligible for TennCare Medicaid benefits upon admission to a medical institution is a group the regulations describe as "individuals who would be eligible for Aid to Families with Dependent Children (AFDC) if they were not institutionalized". In July 1996 the

AFDC program was reauthorized and is now called Temporary Assistance for Needy Families or TANF. In Tennessee, TANF operates under a waiver called the Families First (FF) program. TennCare Medicaid benefits are available to the institutionalized individual who may be a deprived dependent child as defined by the FF regulations or the child's caretaker relative during the confinement period. These individuals must meet all the technical and financial requirements of the FF cash assistance program, as well as one technical and two general financial requirements specific to TennCare Medicaid recipients. A comprehensive list of all these requirements follows this introduction. The information in this section is limited to a ***listing*** of the policy required to make an eligibility determination only. The policies and procedures needed to make a full determination of FF eligibility are located in the Families First Handbook.

When processing this type of eligibility determination, if the caseworker observes that the aid group might qualify for cash assistance, a referral should be made for application for Families First. Eligibility for cash assistance includes a cash payment as well as TennCare Medicaid benefits for the entire group of eligible individuals, whereas TennCare Medicaid benefits in this coverage group extend only to the institutionalized individual.

The following is a list of general information topics which apply to this group as well as all other TennCare Medicaid groups and are located in this manual:

- Confidentiality standards
- Retroactive benefits
- Services covered in the state plan
- The application process
- Authorizing benefits, including vendor payments
- Case maintenance procedures
- Quality control process
- Appeal process

Technical Requirements

This section outlines the technical requirements for Families First which **must be pursued**. The Families First Handbook must be consulted for adequate information to make an eligibility decision. **Those areas which are specific to eligibility for institutionalized individuals are in bold.**

- Prohibition against concurrent receipt of benefits
- U.S. citizenship
- Tennessee residency
- Dependency of a child

  The child must be under age 18, deprived of parental support or care, and living with a relative within the specified degree of relationship, or the individual must be the relative caretaker of a dependent child as described.
- Age
- Living with a relative

- Deprivation.

  NOTE: The parent's confinement to a LTCF constitutes continuous absence.

- The work requirement is not pursued if incapacity is being sought as an exemption for the individual.

- Institutional Status. In order to be eligible for TennCare Medicaid benefits as a member of this coverage group, the individual must have been voluntarily confined to a medical institution (i.e. not an inmate) during the period for which he requests coverage.

The individual must be confined to a medical institution or have been so confined in at least one of the three months immediately preceding the application month.

Financial Requirements

This section outlines the financial requirements for Families First which **must be pursued**. The Families First Handbook must be consulted for adequate information to make an eligibility decision. **Those areas which are specific to eligibility for institutionalized individuals are in bold.**

- Assignment of third party medical benefits.

- Application for other benefits

- Financially responsible relatives

- Income

- Budgeting - For purposes of this coverage group, the assistance group is composed of one person, the institutionalized individual. The budget group is that group of individuals whose income is considered in determining eligibility for the assistance group. Financial responsibility for individuals who live together is limited to spouse for spouse and parent for child.

- Resources - Federal regulations provide for the exclusion of the value of some assets in their entirety or based on their current or intended use. SSI resource policy as applied to institutionalized individuals is addressed in the Chapter on Resources located in this Manual. This policy allows for the exclusion of certain liquid/non-liquid assets which are not resource exclusions for this "would be eligible for FF" group. These exclusions to resources DO NOT apply to this group: exclusion of income-producing real property; exclusion of the CSV of life insurance if the face value is $1500 or less; exclusion of one motor vehicle regardless of value; and exclusion of assets as part of a burial reserve.

Federal and state laws require that any applicant or recipient who transfers an asset for less than fair market value within 36 months of his application or eligibility reevaluation for TennCare Medicaid benefits is presumed to have executed the transfer for the purpose of establishing or continuing TennCare Medicaid eligibility. The uncompensated value of the transferred asset is considered an available and countable resource for the purpose of determining financial (resource) eligibility for TennCare Medicaid benefits. This topic is addressed in full in the Resources Chapter of this Manual.

The Eligibility Decision

The individual who fails to fulfill all the technical and financial eligibility requirements is not eligible to receive TennCare Medicaid benefits. An individual who fails to meet the financial eligibility criteria may be eligible for benefits under the higher income standard of the Medicaid Income Cap (MIC) after a full calendar month's confinement, provided he can fulfill the more stringent disability requirement.

Extend benefits to the applicant who meets all the technical/financial eligibility requirements. Benefits are NOT extended to the entire budget group but are limited to the institutionalized individual.

The TennCare Medicaid eligible individual confined to a LTCF may be eligible for TennCare Medicaid vendor payments that cover the majority of the cost of his care.

SSI PASS ALONGS AND PICKLE CASES

Policy Statement

Legal Base: PL 94-566, Section 503

TennCare Medicaid benefits are extended to individuals who would be eligible for SSI payments but for increases in their Social Security benefits due to cost-of-living adjustments (COLA). Individuals who meet all other financial and technical eligibility requirements remain eligible for TennCare Medicaid if:

- They were eligible for and received both Social Security and SSI for the same month at some time since April, 1977. The SSI recipient who receives Social Security (SSA) retroactive benefits is considered for Medicaid/TennCare purposes to have received SSI and SSA in the same month, if SSA eligibility overlaps a month the individual also received SSI benefits;

- They lost eligibility for SSI for some reason since April, 1977;and

- They currently receive Social Security benefits authorized under Title II of the Social Security Act; and

- They presently have countable income equal to or greater than the SSI Federal Benefit Rate (FBR);

- Their countable income, after deduction of all applicable COLAs is less than the FBR

SSI Pass Alongs

These are individuals who lose SSI eligibility **because of a Social Security cost-of-living adjustment** but would be SSI eligible if the COLAs were disregarded. TennCare Medicaid eligibility is automatically continued for these individuals until determined ineligible by DHS.

Pickle Cases

Individuals who lose SSI eligibility for **some reason other than a Social Security cost-of-living adjustment** but would be eligible for SSI if the COLAs received since their SSI termination were disregarded may continue to receive TennCare Medicaid. The individual must make an application for TennCare Medicaid benefits under this provision.

Technical Eligibility Requirements

All technical requirements must be verified at the initial application/review and all subsequent annual reviews. Details on each technical requirement may be found in the Chapter of this Manual designated for that topic.

- Prohibition against concurrent receipt of benefits.

- Citizenship or qualified legal alien status

- Tennessee residency

- The individual must have attained at least age 65 or meet the requirements of blindness or disability.

- The individual must be currently eligible to receive Social Security benefits as authorized under Title II of the Social Security Act.

Financial Requirements

All financial requirements must be verified at the initial application/review and all subsequent annual reviews. Details on each financial requirement may be found in the Chapter of this Manual designated for that topic.

- Application for other benefits

- Third party support assignment

- Financially responsible relatives

Income

The individual is income eligible if his net countable income after excluding all appropriate Social Security COLA is at least $1.00 less than the appropriate SSI Federal Benefits Rate (FBR).

Disregard

- All Social Security COLAs that caused or have occurred since the SSI termination.
- The spouse's COLAs that caused or have occurred since the SSI termination if the individual has income deemed to him/her from the ineligible spouse.
- All Social Security COLAs of the child and the parent(s) which have occurred since the SSI termination.

Determining the Amount of the COLAS

Individuals may have one or more COLAs to disregard at the time of application or reapplication. The chart at the end of this Chapter lists the Conversion Factors used to determine the total COLAs to disregard beginning May 1, 1977. Follow the steps below to determine the COLA amount to disregard:

- Verify the current Social Security amount.
- Verify the SSI termination date.
- Multiply the current SS amount by the conversion factor matching the month and year of SSI termination.
- Compare result to current SSI FBR.

Budgeting Procedures

- Determine all of the individual's countable income including In-Kind Support and Maintenance (ISM – refer to details following in this Chapter) and income deemed from an ineligible spouse/parent.
- From unearned income, subtract the $20 general disregard. From earned income subtract the remainder of the $20 general disregard not fully applied to the unearned income AND $65.00 plus one-half of the remainder.
- Combine the net income and compare to the current SSI FBR.
- If there is a deficit of $1.00 or more, the individual is not eligible as a Pass Along or Pickle case. Refer the individual back to SSA for a SSI application.

- Disregard all COLAs from SS benefits received by the individual (and ineligible spouse or parent(s), if applicable) at or since the termination of SSI.

- Compare the adjusted income to the current FBR for an individual.

Budgeting Procedures in Combination Cases/Budgeting Income of an Ineligible Spouse

- Do not budget the income of an ineligible spouse to the eligible individual that is based on need and provided by a federal, state, or local agency (e.g., FF or VA pensions, etc.) OR that is used in determining the amount of the assistance based on need.

- Deduct a living allowance for each ineligible child (i.e. deeming 1/3 FBR for an ineligible child minus the child's own income) from the ineligible spouse's unearned income first and any remaining allowance from the ineligible spouse's earned income.

- Compare the remaining income of the ineligible spouse to one-half of the FBR for an individual.

- If the ineligible spouse's countable income is equal to or less than ½ the FBR, work a budget for the eligible individual alone with no spouse AND do not allocate any income from the ineligible spouse.

- If the ineligible spouse's countable income is greater than ½ the FBR for an individual:

    - combine the ineligible spouse's unearned income with the eligible's unearned income and apply the $20 disregard.

    - combine both their earnings and deduct the $65.00 = ½ of the remainder work disregard.

    - Total the net unearned and earned income.

    - Subtract the appropriate COLAs from SS benefits.

    - Compare the adjusted income (after disregards and COLA deductions) to the current FBR for a couple.

    - Deny the application or close the active case if the income is greater than the FBR for a couple.

Individual with an Eligible Institutionalized Spouse

During the month of admission and thereafter, consider the couple separated and budget as an individual if the individual is confined to a LTCF.

Budgeting the Income of Parents

- Deduct from the income of the parents of an eligible child who is not institutionalized the court ordered support payments or the verified amount actually paid, whichever is less, and a living allowance for each ineligible dependent child in the home (i.e. deeming 1/3 FBR for an ineligible child minus the child's own income).

- After allocation (living allowance) to the ineligible children, make the following deductions depending on the type of income:

    - From earned income only, deduct the $20.00 general disregard, deduct $65.00 + ½ of the remainder, deduct parental living allowance of twice the monthly FBR for an individual for one parent residing in the home and twice the monthly FBR for a couple if two parents are in the home.

    - From unearned income only, deduct the $20.00 general disregard and deduct the monthly FBR for an individual or a couple (depending on whether one or two parents are in the home).

    - From a combination of both unearned and earned income, deduct $20.00 general disregard from unearned income, deduct the remainder of the $20.00 not offset by unearned income and $65.00 + ½ of the remainder from earned income. Combine the remaining earned and unearned income and deduct the monthly FBR for an individual or couple, as appropriate.

    - Deem any remaining income to the eligible child who is not institutionalized and treat as unearned income, subject to the $20.00 general disregard.

    - Do not deem from the parent to the child if the child is institutionalized.

Eligible Individual with a Families First, AFDC Medicaid Only, or Medically Needy for Children under 21 or Pregnant Adults

- Budget the individual's income using procedures given in this Chapter. Do not allocate from the Families First cash assistance group to the SSI Pass Along/Pickle individual or to dependents from the Pass Along/Pickle individual.

- Budget the Families First/Medicaid Only/Medically Needy cases as appropriate for that assistance category.

- Do not disregard COLAs when allocating from the Pickle/Pass Along individual to his/her FF/MO/MN aid group.

DISABLED WIDOWS/WIDOWERS

Disabled Widows/Widowers Part II – Spousal Retirement Benefits

Policy Statement

Legal Base: OBRA, Section 9116, Public Law 100-203

Disabled widows/widowers (w/w) who received SSI benefits prior to age 60 and received a spouse's Title II retirement benefit upon reaching age 60 and lost SSI eligibility because of that benefit will be deemed eligible for SSI from age 60 until age 65 if they are not eligible for Medicare Part A benefits and remain SSI eligible on all other eligibility areas. The w/w will continue to be deemed SSI eligible as long as the w/w would be eligible for SSI on his/her own disability but for the Title II benefit and the w/w is not entitled to Medicare Part A benefits. This Medicaid eligibility category will apply to all disabled w/w who are already between the ages of 60-65 who lost SSI due to the receipt of a Title II spouse's retirement benefit at age 60, and all others who reach age 60 on or after 7-1-88.

Any disabled w/w is categorically needy for Medicaid for any month in which he/she is entitled to a Social Security benefit, but is not eligible for SSI, if he/she:

- Was eligible for SSI based on his/her disability prior to age 60;
- Was entitled to the w/w benefit at age 60;
- Lost SSI eligibility in the first month that his/her w/w benefit was paid;
- Has been continuously entitled to w/w benefit from the month that the benefit was authorized;
- Would be eligible for SSI if that w/w entitlement and all subsequent COLAs are disregarded.

Individual's eligibility for Medicaid under this category is effective the date SSI terminated. SSA will notify the individual w/w who lose SSI payment for this reason after 7-1-88. The DHS county office will:

- Accept applications from those individuals requesting assistance.
- Verify that the only reason the individual became SSI ineligible was due to entitlement to w/w's benefits at age 60.
- Disregard the amount of the w/w benefits which exceeds the appropriate SSI-FBR at initial entitlement and/or subsequent COLAs.

- On AEFPP, enter Reason Code "02".

- Determine whether the individual meets SSI eligibility on all other points of eligibility using the criteria for determining income and resource eligibility for Pickle cases as listed in the Chapter on SSI Pass Along and Pickle cases.

- Authorize eligibility for Medicaid if the individual remains eligible.

- Identify in running record comments (CLRC) that future reviews of this case must be done by the eligibility policies applicable to the w/w Part II case.

- Review the case annually and terminate coverage when appropriate.

Disabled Widows/Widowers Part III – Disability

Policy Statement

Legal Base: OBRA 1990, Section 5103

Section 5103 of the Omnibus Budget Reconciliation Act of 1990 (OBRA) eliminated the special, more restrictive disability test for widows/widowers and for disabled surviving divorced spouses. Prior to this change, these individuals were not eligible for SS disability benefits unless they were unable to perform any gainful activity. That requirement is changed to conform to SS standard definition of disability, which requires that individuals be unable to perform any substantial gainful activity. As a result of this change, a number of individuals eligible for SSI benefits became eligible for SS disability (Title II) benefits. Because of this increased income, these individuals may lose SSI benefits and the accompanying Medicaid eligibility. The SSA implemented Title II benefits for these cases in April 1991. SSA will refer these cases to DHS for Medicaid continuation without loss of coverage.

A third deemed SSI group is created for those widow/widowers to restore their categorical Medicaid eligibility. They will be deemed eligible if:

- They were receiving SSI for the month prior to the month they began receiving the Title II SS benefit;

- They would continue to be eligible for SSI if the amount of the Title II SS benefit was not counted as income; and

- They are not entitled to Medicare Part A.

Section 5103 also provides that each month of SSI eligibility will count toward the individual's 5-month disability waiting period and the 24-month Medicare waiting period. The normal wait for disability benefits and/or Medicare may be greatly reduced or eliminated. Therefore, an individual may or may not be eligible for deemed categorical Medicaid coverage, depending on when they become entitled to Medicare Part A based on a reduced waiting period.

The DHS county office will:

- Accept applications from individuals specifically requesting Medicaid continuation as a result of SSI loss due to increased income from SS disability eligibility under Section 5103;

- Include this coverage group when scanning potential Medicaid eligibility for all applicants. These potential cases can be identified on SOLQ by a payment status code of N01 (excess income), unearned income type code A (Title II income), frequency code C (continuing) and Beneficiary identification code which is the SS number plus one of the following suffixes: W, W1 through 9, WB, WF, WG, WJ, WR, WT.

- Verify that the only reason for SSI loss was due to entitlement to SS disability benefits resulting from the change in the definition of disability.

- Disregard the amount of the SS benefit which exceeds the SSI-FBR at initial entitlement and/or subsequent COLAs.

- Determine whether the individual is eligible for Medicare Part A.

- Determine whether the individual meets SSI eligibility on other points of eligibility using criteria for the Pickle case determination located in the Chapter on SSI Pass Along and Pickle Cases in this Manual.

- Authorize continuing Medicaid eligibility if the individual remains eligible.

- Identify in the running record, CLRC, that this is a DWW-3 case to ensure that future reviews will be made under the applicable policies.

- Set an Expected Change in ACCENT for the month and year the individual will be eligible for Medicare Part A.

- Review the case yearly and terminate coverage as necessary.

DISABLED ADULT CHILDREN

Policy Statement

Legal Base: PL 99-643, Section 6

Medicaid benefits are extended to individuals who would be eligible for SSI payments but for entitlement to OR increase in the amount of the Disabled Adult Child's (DAC) Social Security benefits. When SSI recipients lose SSI eligibility because of entitlement to OR an increase in SS Disabled Adult Child benefits, they remain eligible for Medicaid as long as they meet SSI eligibility criteria, except for the receipt of or change in the amount of their Social Security benefit.

This coverage applies to an individual who is at least 18 years of age AND is receiving SS benefits as a Disabled Adult Child on the basis of blindness/disability which began before age 22.

DHS County Office Responsibilities

- Accept applications from individuals requesting assistance.
- Verify that the individual lost SSI due to entitlement to or increase in the DAC benefit.
- Disregard the amount if initial entitlement or increases.
- Determine if the individual meets SSI eligibility on other technical and financial requirements.
- If the individual is ineligible using the income disregards, determine whether eligibility is met under any of the other Medicaid coverage groups.
- Notify the individual of his eligibility or ineligibility.
- Technical Eligibility Requirements and Financial Requirements must be reviewed according to policies outlined in the appropriate Chapters of this Manual.

Income and Budgeting

The individual is income eligible if adjusted net accountable income is at least $1.00 less than the applicable SSI-FBR. ISM applies to income determination (see SSI Pass Along and Pickle Cases Chapter). All COLAs which occur at the time of SSI ineligibility and thereafter are disregarded for the DAC and spouse. The entire initial entitlement DAC-SS benefit is disregarded when the initial entitlement caused SSI ineligibility. If the increase in the DAC benefit caused SSI ineligibility, the amount of the increase is disregarded.

The individual will have an entitlement/benefits increase letter from the SSA verifying the benefit amount. Individuals may have one or more COLAs to disregard. The chart in Appendix lists COLA Conversion Factors used to determine the total COLAs to disregard beginning May 1, 1977. Follow these steps to determine DAC benefits and COLA increases:

- If the initial entitlement to DAC caused SSI ineligibility, verify the current SS amount and enter this amount on AEFPP under the “Initial Entitlement” field. The SSI Termination Reason will be “02”.
- Verify date SSI was terminated.
- If the increase in the DAC caused SSI ineligibility, compare the DAC-SS amount prior to SSI termination with the DAC-SS amount after SSI termination.

- Disregard the difference, or the amount of the increase, and enter this amount on AEFPP under "other SSA Non-COLA" field.

- Multiply the current SS amount by the conversion factor matching the month and year of SSI termination.

Budgeting for Individuals

- Determine all of the individual's countable income including In-Kind Support and Maintenance (ISM – refer to details in the SSI Pass Along and Pickle Cases Chapter).

- From unearned income, subtract the $20 general disregard. From earned income subtract the remainder of the $20 general disregard not fully applied to the unearned income AND $65.00 plus one-half of the remainder.

- Combine the net income and compare to the current SSI FBR.

- Approve for TennCare Medicaid if the income is equal to or less than the FBR for an individual OR deny/close if the income is more than the FBR.

Budgeting for Couples

- Individuals may continue to be DAC eligible if they marry a Social Security beneficiary eligible for DAC benefits, disability benefits, widow/widowers benefits, or regular retirement benefits.

- Individuals will NOT continue to be DAC eligible if they marry a Social Security beneficiary under the age of 19 or an individual of any age who is not a SS beneficiary.

- Budget DAC eligible together as an eligible couple.

- Follow the budget steps above for an individual, except compare the adjusted net income to the current couple SSI-FBR.

Individual with Eligible Institutionalized Spouse

During the month of admission to the institution and during the month(s) following admission, consider the couple separated and budget as an individual if 30 days continuous confinement is met. F**or individuals applying to enroll in the HCBS waiver program, during the month the individual is determined to need and to be likely to receive services for a continuous period of at least 30 days going forward, consider the couple separated.**

Eligible Individual with a Families First or AFDC Medicaid Only or Medically Needy for Children under 21 or Pregnant Adults

- Budget the individual's income using procedures given in the SSI Pass Along and Pickle Case Chapter in this Manual. Do not deem from the Families First cash assistance group to the DAC individual.

- Budget the Families First/Medicaid Only/Medically Needy cases as appropriate for that assistance category.

- Do not disregard COLAs or DAC entitlement/increases when allocating from the DAC individual to his/her FF/MO/MN aid group.

Determining In-Kind Support and Maintenance (ISM)

In-Kind Support and Maintenance (ISM) is considered unearned income in the determination of financial eligibility for SSI, Pass Alongs, Pickle cases, Disabled Adult Child (DAC) and Disabled Widows/Widowers.

I**SM**. - In-Kind Support and Maintenance is counted as unearned income (except the Value of One-Third Reduction [VTR]) to the individual when he/she receives food, clothing, and/or shelter from sources inside and/or outside the household. (1/3 FBR for individual or couple)

Maintenance - Maintenance is shelter. Shelter means living quarters for an individual and any shelter items such as mortgage payments, property insurance, rent, utilities and real property taxes.

Support - Support is food and/or clothing received by an individual for which he/she has no liability.

Presumed Maximum Value (PMV) - The PMV is the highest value that can be assigned to in-kind support or maintenance (ISM). It is equal to one-third of the full FBR for an individual plus $20.00.

Value of One-Third Reduction (VTR) - The VTR is the value which the law assigns to the ISM the individual receives while living in the household of another and receiving both food and shelter. The VTR is:

- Not subject to the $20 general income exclusion
- Not reputable as is the PMV
- Equal to one-third of the full FBR for one
- Used in budgeting instead of the full FBR and not as unearned income.

NOTE: The PMV and VTR are mutually exclusive. If the VTR applies, no other additional ISM is chargeable.

Establishing the Existence of ISM

If an individual cannot establish ownership interest, rental liability or that he/she equally shares household expenses, it must be determined if he/she receives both support AND maintenance in-kind. The individual's contribution towards household expenses must not be a token amount. His/her contribution must be equal to or at least the current market value of the item(s) (or within $5 of the value) or equal to his/her share of these items that his/her payment is intended to include. For example: An individual shares a house with another individual and pays $10 a month toward rent and utilities which average $120 a month. It is determined that the individual's contribution does not cover his pro rata share of expenses (one half of rent and utilities of $60). ISM must be determined for the individual.

Value of ISM

When an individual receives both food and shelter from a source within the household, the value of the ISM is equal to a one-third reduction in the appropriate FBR. Use the VTR to determine eligibility in these situations. When an individual receives both food and shelter from a source outside the household, use the PMV as unearned income.

When an individual receives only food or only shelter from a source either in or outside the household, the value of the item as unearned income is placed at the PMV.

Use the PMV to value in-kind income (as described above) unless the individual can substantiate that the value of the item received is less than the PMV. Determine the actual value by dividing the current market value of the item by the number of persons who received the ISM. The result is the client's share which is reduced by any contribution he/she made toward the item. Compare this result to the PMV and use the lesser amount as the ISM value.

If the client is an owner, renter, or pays equal share of the household's food and shelter expenses, use the full FBR.

ISM
To Determine Value of ISM use VTR or PMV

VTR	PMV
1. If the individual/couple receives Food and Shelter from within the household, test income against VTR instead of the full applicable FBR. Living Arrangement Code 05 2. 1/3 of individual/couple FBR is subtracted from the full applicable FBR to obtain the value of the VTR.	1. If the individual/couple receives food **AND** shelter from **Outside** the household, add PMV to income and test against the full applicable FBR. If the individual/couple receives food or shelter from **Within** the household, add PMV to income and test against the full applicable FBR.

3. Not subject to the $20 general income exclusion 4. Value is not reputable. 5. Don't use as unearned income. 6. No other ISM is chargeable if VTR applies.	If individual/couple receives food **OR** shelter from **Outside** the household, add PMV to income and test against full FBR. 2. The PMV is 1/3 of the individual FBR for 1 + $20. 3. The PMV is used as unearned income. 4. Subject to $20 general income exclusion allowed on unearned income. 5. The value of the PMV is reputable. 6. If a service valued greater than the PMV is actually provided for the individual, only the PMV is used as unearned income.

Resources

For SSI Pass Along/Pickle cases, the limit is $2,000 for an individual and $3,000 for two persons. Refer to the Chapter on Resources for policy and procedures concerning countable and excludable resources and other information.

QUALIFIED MEDICARE BENEFICIARIES (QMB)

Policy Statement

Legal Base: Public Law 100-360 Section 301

The Medicare Catastrophic Coverage Act (MCCA) of 1988 mandated coverage for individuals who are entitled to and have Medicare Part A and who meet specified resource and income standards. The coverage will provide for payment of Medicare premiums and coinsurance and deductibles of Medicare covered services. MCCA mandated implementation of this program was effective 1-1-89.

Individuals may be eligible for this coverage if they are entitled to and have Medicare Part A, and their total countable resources do not exceed 200% of the SSI resource limit ($4000 for an individual and $6000 for two or more persons). Also, their income must be equal to or less than 100% of the Federal Poverty Level.

Technical Requirements

All technical requirements must be verified at the initial application/review and all subsequent annual reviews. Details on each technical requirement may be found in the Chapter of this Manual designated for that topic.

- Concurrent receipt of benefits
- Citizenship
- Enumeration
- Institutional status
- Assignment of medical support rights
- Enumeration. In addition to verification of a Social Security number or application for one, verification must be furnished of the individual's entitlement to and receipt of Medicare Part A benefits.

Financial Requirements

All financial requirements must be verified at the initial application/review and all subsequent annual reviews. Details on each technical requirement may be found in the Chapter of this Manual designated for that topic.

- Application for other benefits
- Third party support assignment

Financially responsible relatives (FRR)

The income and resources of an applicant/recipient (AR) in-home spouse (or parent if the individual is unemancipated and under the age of 18) are considered available to the AR, regardless of whether they are actually contributed. Apply the FRR policy as detailed in the Chapter of this Manual for institutionalized individuals. For non-institutionalized individuals living with a spouse, the income and resources are considered together and compared to the standards for a couple (or the family size if dependent children are also included in the budget group). See Chapter for "holding out" relationships. For non-institutionalized individuals who are under age 18 and unemancipated living in the home with parent(s), the parent's income is considered available to the AR and counted in the individual's budget.

Resources

Countable and excludable resources include those items discussed in the Resources Chapter of this Manual. The total countable resources of an individual and his/her FRR in the home are compared to twice the SSI resource limit for an individual or couple. Transfer of assets policy applies. Please refer to the Resources Chapter for information regarding the application of the transfer of assets policy which applies to QMBs who are:

- Institutionalized and transferred property (other than a transferred homestead under certain specified circumstances) on or after July 1, 1988 and within 36 months prior to application made July 1, 1988 or later.

Income

Countable and excludable incomes discussed in the Income Chapter apply to the QMB coverage group. The total income of the individual, couple, or family is compared to 100% of the poverty level income standard (PLIS) for the budget group size.

Budget Group Composition

The budget group must include the needs and income of the individual and his/her FRR living in the home. The budget group may include also the needs of the individual's and/or his/her spouse's minor children living in the home if to the budget group's advantage. The countable income of all budget group members whose needs are included must be counted also. The budget group may include:

- the individual only if the individual lives alone or the individual does not live with a FRR; or
- the individual and his/her in-home spouse; or
- the individual, his/her in-home spouse and dependents (if to the advantage of the individual); or
- the individual and his/her dependents (if to the individual's advantage) when there is no FRR in the home.

Budgeting

To determine QMB income eligibility, develop the budget group as indicated:

- Total the countable unearned income of all the budget group members, deduct the $20 general disregard,
- If there are earnings, deduct the remainder of the $20 general disregard not deducted from unearned income and apply the $65 and ½ of the remainder to earnings.
- Add the net unearned and earned income together.
- Compare the total net income to the 100% PLIS for the budget group size.
- If the income is equal to or less than 100% PLIS, the individual or couple is income eligible for QMB.
- If the income is greater than 100% PLIS, the individual is not QMB eligible.

Procedures

- QMB is a form of medical assistance for individuals meeting certain criteria. This assistance pays the Medicare premium and the coinsurance and deductibles of Medicare covered services.

- To be eligible for QMB an individual must be eligible for Medicare Part A, income must be equal to or less than the 100% PLIS, and resources such as bank accounts, stocks, bonds, etc. may total up $4000 for an individual and $6000 for a couple.

- Individuals wishing to apply for QMB may be mailed the application form (HS-0169) or individuals may come to the DHS office to file an application.

  A face-to-face interview is not required to determine eligibility for these individuals. Questionable information must be resolved with the client and/or his/her responsible person before an eligibility determination is made.

- All technical requirements such as residence, enumeration, assignment of rights, etc. must be met for this coverage group.

- For those individuals with earnings who are not obviously ineligible, additional verification may be requested.

- Eligibility for QMB begins the month following the month of approval. For example, an application is approved in January 2005. Eligibility date is 2-1-05. There is no provision for retroactive eligibility unless a case decision is reversed during an appeal.

- QMB eligibility will establish Part B Medicare effective the month after approval even if the individual had previously refused this coverage. It is not necessary to refer these individuals to the Social Security Administration.

Applicants without Medicare Part A

Individuals who do not have Part A may be referred to the local Social Security office for enrollment. The enrollment period extends from January 1 to March 31 each year. Entitlement does not begin until July of the same year. The individual who has been enrolled will be provided with a Social Security Notice of Entitlement effective July. Individuals applying for QMB prior to July who meet the QMB eligibility requirements may be approved in June with QMB beginning effective July.

Case Maintenance

The PLIS will increase around March or April each year and revised standards will be issued at that time. Individuals currently eligible for QMB but whose SSA COKA increase causes income ineligibility must remain eligible until the new poverty guidelines are available.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES (SLMB)

Policy Statement

Legal Base: Social Security Act – Section 1902 and 1905

Effective January 1, 1993, Section 4501 (b) of the Omnibus Budget Reconciliation Act (OBRA) of 1990 required states to pay Medicare Part B premiums for individuals whose income exceed QMB standards but is less than a specified higher percentage of Poverty Level. The coverage is called Specified Low-Income Medicare Beneficiaries (SLMB). SLMB is similar to QMB with these exceptions:

- Eligibility is based on a higher income standard of 120% of the PLIS.
- The only benefit is payment of the Part B Medicare premium.
- SLMB eligibility may serve to establish Part B Medicare coverage for individuals who had earlier refused this coverage. Since no premiums were withheld in this situation, no refund is due.
- Individuals may be eligible for this coverage if entitled to or receive Medicare Part A due to attaining age 65 or receipt of Social Security disability for 24 months.
- Countable resources may not exceed 200% of the SSI resource limit or $4000 for an individual and $6000 for two or more.
- Net income must be equal to or less than 120% of the PLIS.

Technical and Financial Requirements

These requirements are exactly the same as for QMB which can be found in this Manual in the Chapter on QMB. The QMB chapter also refers readers to other chapters in this Manual for detailed instructions on specific topics.

Income

Please refer to the Chapter on Income for countable and excludable income that applies to SLMB.

Budgeting

- The budget group composition is identical to the QMB budget group as outlined in that chapter.

- All unearned and earned income of each budget group member should be recorded on the appropriate screen in the data field.

    - Apply the $20 general disregard to unearned income, and

    - Deduct $65 and ½ from all earned income, if any, and

    - Compare the remainder to 100% of PLIS looking for QMB eligibility and if that income is too high,

Procedures

SLMB is a form of medical assistance for individuals meeting certain criteria whose income exceeds the QMB income standard. This assistance pays for Medicare Part B premium only. If Part B was previously refused by individuals who have Part A, the SLMB approval will establish Part B coverage.

Applications should be filed using the application form, HS-0169. Interviews may be face to face, telephone, or by home visit.

Verify only questionable information for QMB/SLMB eligibility. Verification of SS or SSI income should not be requested from the individual if it can be secured by the caseworker and is not questionable.

Please ensure that:

- the name as appears on the Medicare card.
- AEIDP is completed thoroughly, and
- the claim number is on AEFMI and AEFMC. Only use claim numbers taken from the Explanation of Medicare Benefits (EOB), Medicare card, or data matches on ACCENT.

Fiats may be required for QMB/SLMB when case changes are made during the usual COLA each January and prior to adjustments to the PLIS which is usually published in February and effective March or April.

Qualifying Individuals (QI1)

The Balance Budget Act (BBA) of 1997 created a new category of eligibility for States to assist qualified individuals in payment of Medicare Part B premium. This new category is in addition to the QMB and SLMB categories.

Any individual may qualify for the QI1 category by meeting the following requirements:

- Must have income over 120% of PLIS but no more than 135% of PLIS;
- Must have resources below or at $4,000, and

- Must not be enrolled in TennCare Medicaid or TennCare Standard.

QI1 pays only the current Medicare Part B Premium; it does not pay additional medical benefits. Once an individual has been approved for QI1 the recipient will remain eligible for this benefit for the remainder of the current year. Eligibility must be re-determined in December is order to qualify for the next year.

Eligibility for QI1 may begin the month of application and may continue until the end of the calendar year. There is no retroactive provision for this category.

QUALIFIED DISABLED WORKING INDIVIDUALS (QDWI)

Policy Statement

Legal Base: OBRA, Sections 6012 and 6048(d)

Section 6012 of the Omnibus Budget Reconciliation Act (OBRA) of 1989 provides for certain disabled working individuals (DWI) under age 65 who have exhausted their Medicare coverage an option to purchase Medicare Hospital Insurance Benefits (Part A) for an indefinite period.

Disabled Working Individuals (DWI) are responsible for paying the Medicare premium themselves if their income is more than 200% of the PLIS, or their resources exceed twice the SSI resource standard for an individual/couple, or they are recipients of full TennCare Medicaid coverage.

The SSA will enroll those individuals for DWI coverage. The individual will have a 7 month period to enroll with the SSA beginning with the month of the notice. If they do not enroll during that time, they may enroll during the annual general enrollment period, January – March of each year. Delayed enrollment during the 7 month period will result in a delay in their entitlement date under these provisions. Enrollment during the general enrollment period delays entitlement until the following July 1.

If the individual is enrolled as a DWI more than 3 months prior to becoming eligible as a Qualified Disabled Working Individual (QDWI), the individual may be responsible for the premiums in the months prior to QDWI eligibility.

Section 6048(s) of OBRA 1989 requires states to "buy in" the Medicare Part A only premium for those DWIs who meet all the requirements of being a "qualified disabled working individual". Individuals meet those requirements if they:

- Are "entitled to enroll" for hospital insurance benefits under Part A based on Section 1818A, added by Section 6012 of OBRA 1989, of the Social Security Act. (The SSA will make that decision and notify DHS.), AND

- Have income based on SSI rules equal to or below 200% of the PLIS, AND

- Have resources based on SSI rules which do not exceed twice the SSI resource limit for an individual/couple, AND

- File an application with DHS, AND
- Are not otherwise eligible for medical assistance under any Title XIX (Medicaid) coverage group, AND

- QDWIs must also meet general nonfinancial requirements of eligibility for Medicaid as found in this Manual: enumeration, citizenship, Tennessee residency, and assignment of rights.

This coverage will apply to anyone who ever lost Medicare eligibility due to returning to work. July 1990 is the first possible month of coverage regardless of when Medicare eligibility was originally terminated, AND for no more than the 3 months immediately preceding the month in which the QDWI eligibility determination was completed.

QDWIs eligibility does NOT cover (pay for): Part B Medicare premiums, co-insurance or deductibles.

Social Security Administration's Responsibility

- Make the determination of continuing disability on all cases;

- Make the determination that income exceeds the substantial gainful activity (SGA) limits;

- Notify the individual of Medicare termination and the opportunity to purchase continued coverage paid either by them or by Medicaid.

- Enter each case on Social Security's system as eligible or ineligible for DWI enrollment; AND

- Refer by computer listing that individual to DHS if it appears he/she meets the income and resource requirements for QDWI eligibility.

DHS County Office Responsibilities

- Provide an application form, HS-0169, to DWIs who request to file an application.

- Make necessary eligibility verifications which will result in a determination as to whether the individual is Medicaid eligible. (If Medicaid and/or QMB eligible, the DWI is ineligible as a QDWI);

- Take action to deny or approve coverage and notify the individual of his/her eligibility or ineligibility.

Technical and Financial Requirements

Apply all technical and financial requirements as apply to the QMB program. Details are contained in the chapters of this Manual.

Resources

The limit is twice the SSI resource limit for an individual or couple. Refer to the Chapter on Resources for policy and procedures concerning countable and excludable resources and other information.

Income

Please refer to the Chapter on Income for countable and excludable income that applies to QDWI.

Compare the total income of the individual/couple to 200% of the PLIS for an individual/couple, as applicable, in effect at the time for which eligibility is being determined.

Use the QMB procedures to determine the budget group and figure the budget.

Procedures

- Approvals will be effective the first day of the application month or the initial month of eligibility if later.
- An annual review of eligibility will be made on QDWI cases.
- No TennCare Card will be issued for QDWIs. The Approval Notice of Disposition will be the individual's proof of eligibility.
- The Centers for Medicare and Medicaid Services (CMS) will issue a Medicare card to the QDWI eligible individual indicating the change made about the individual's Medicare eligibility.
- An individual will lose QDWI eligibility when:
    - He/she becomes eligible for any category of TennCare Medicaid coverage for any period of time, OR
    - Resources exceed the resource limit, OR
    - Income exceeds 200% of the PLIS in effect at the time, OR
    - He/she becomes age 65 and is eligible for free part A Medicare, OR
    - SSA notifies DHS that the individual no longer meets the disability requirements.

GRANDFATHERED-IN MEDICAID ONLY

Policy Statement

Legal Base: 42 CFR 435-132

Title XVI of the Social Security Act created the Supplemental Security Income program (SSI), a national and entirely Federally funded program for the aged, blind, and disabled that replaced a variety of Federal-state supported programs for this group. Prior to the enactment of Title XVI in January 1974, these individuals were eligible in nonstandard assistance programs variously referred to throughout the states as Aid to the Blind (AB), Aid to the Potentially Self-Supporting Blind (APSB), Aid to the Disabled (AD), Aid to the Totally and Permanently Disabled (ATPD), Aid to the Aged or Old Age Assistance (OAA). In addition to this confusing array of program names, states provided a wide range of program benefits and grants with the result that some eligible individuals enjoyed, with the addition of "special needs" to their budgets, larger assistance payments than initially authorized by the SSI program in 1974. Legislation provided for these individuals in the creation of the mandatory State Supplementary Payment (SSP) provision.

In recognition of the fact that some of the financial requirements of the SSI program would adversely affect a group of eligible institutionalized individuals in many of the states, Title XIX of the Social Security Act provided for mandatory Medicaid coverage for those individuals who "were eligible for Medicaid in December 1973 as inpatients of medical institutions or residents of intermediate care facilities and who continue to meet Medicaid eligibility requirements in effect under the state's plan in December 1973 for institutionalized individuals, who remain institutionalized and who continue to…need institutional care." The GRANDFATHERED-IN MEDICAID ONLY coverage group was created.

The group continues to receive benefits at least equal to those provided prior to 1974 but their eligibility is based on pre-1974 requirements. The level of their assistance is limited to the benefits of the Medicaid program only and does not include cash assistance.

The Application Process

Coverage is limited to individuals who were eligible as institutionalized in December 1973 or any part of that month. Accept no new applications for this coverage group. An individual previously eligible as a member of this coverage group may be extended benefits as a Grandfathered-In individual upon his reapplication, if he is ineligible as a member of the coverage group for Institutionalized Individuals. The individual who is no longer eligible as a member of this coverage group is automatically reviewed to determine his eligibility as an institutionalized individual.

Eligibility Requirements

All eligibility factors covered in this Manual for eligibility for TennCare Medicaid benefits apply to this category only the exceptions covered here. Refer for information to the pertinent chapter in this Manual.

The income standard for each eligible individual is $218.00 monthly. The following disregards from gross income are applied to determine countable net income:

- Disregard the first $4.00 (four dollars) of Social Security and/or RRB benefits.
- Disregard the Medicare premium.
- The result is the net income to be compared to the standard of $218.00.
- If the income is less than $218, the individual is income eligible.

Exclude

- An individual may have the value of real property excluded as homestead property and/or income producing property if his total equity value is not greater than $9000.00. The value of real property may be excluded in determining countable assets if it produces at least $60.00 net annual income and the individual's equity value in any excluded real property is not greater than $9000.00.
- Exclude the cash surrender value of all life insurance the individual owns if the total face value is $600 or less.

NOTE: Do not disregard the individual's equity value in burial spaces.

Resource Limit

- The resource limit for an individual is $500.00.
- The resource limit for a couple is $1000.00.

WOMEN DIAGNOSED WITH BREAST/CERVICAL CANCER (BCC)

Policy Statement

Legal Base: Public Law 106-354 2(b) (1)

TennCare Medicaid coverage is extended to women who have pre-cancerous/cancerous breast or cervical cancer. The Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease and Prevention Control (CDC) made available matching funds equal to the Federal Medical Assistance Match used in providing Medicaid eligibility for uninsured children for women who have been diagnosed with Breast and/or Cervical Cancer. These women may receive screening for cancer by the Tennessee Breast/Cervical Cancer Early Detection Program (TBCCEDP) to determine if they have a pre-cancerous or cancerous condition. The centers performing these screenings are located throughout the state. A brochure is available from the Department of Health website at

http://www2.state.tn.us/health/BCC/PDFs/TBCCEDP_ProgBroc.pdf . A list of locations and telephone numbers are provided. A toll free number may be called for more information or to find a site, 1-877-969-6636. There are TBCCEDP eligibility requirements for presumptive eligibility for this TennCare Medicaid category. Only women who meet the TBCCEDP eligibility requirements may be eligible for presumptive eligibility.

Coverage Group

Women who qualify for this category can have continuous TennCare Medicaid coverage if they meet the following conditions:

- Must be uninsured. Uninsured is defined as individuals without "creditable coverage". Creditable coverage includes:
    - Other health insurance including individual plans
    - Group health plans
    - Medicare
    - Medicaid
    - Military health plans
    - Medical care programs of the Indian Health Services or tribal organization
    - State risk pools
    - Federal employee health plans
    - Public health plans
    - Health plans under section 5 (e) of the Peace Corps Act
- Must be under age 65;
- Have been determined to have breast or cervical cancer, including pre-cancerous conditions;
- Be participants of the TBCCEDP program;
- They must not be otherwise eligible for TennCare Medicaid under some other category of coverage;
- They must be a citizen or qualified alien;
- In order to participate in the TBCCEDP program, family income must be under 250% of the Federal Poverty Level.

Presumptive Eligibility Coverage

The TBCCEDP will establish eligibility for presumptive coverage. There is financial screening performed at the TBCCEDP site. Declaration of income is accepted at the TBCCEDP site. When presumptive eligibility requirements are met, the site will complete form HS-2768 and fax to the state office.

Eligibility coverage under presumptive eligibility allows recipients full TennCare Medicaid benefits for a limited time. It provides:

- TennCare Medicaid coverage not limited to treatment of breast and cervical cancer;
- Allows enrollment in TennCare Medicaid for a limited period of time in order for a full TennCare Medicaid application to be processed to determine if the woman is eligible in any other Medicaid category;
- Presumptive eligibility is used to facilitate eligibility in the BCC category if the applicant is not eligible in any other category, so that treatment can be started.
- Tennessee does not cover experimental treatment.

Eligibility for Presumptive TennCare Medicaid begins the day TBCCEDP determines a need for a referral for treatment. The presumptive period ends on the 45th day. If the woman has followed through with a Medicaid application, coverage may continue, providing that ongoing treatment is needed and there is a cancer diagnosis.

Technical Requirements

- Must be a woman
- Must be a U. S. citizen or qualified alien
- Must be a resident of Tennessee
- Must be in need of treatment for breast or cervical cancer.

Financial Requirements after Presumptive Eligibility Begins

Income and resources are not taken into account by DHS in providing continuing eligibility for the BCC category after the presumptive eligibility is approved. However, this information is required for processing the eligibility determination of other TennCare Medicaid categories.

Responsibility of TBCCEDP

If a woman meets the screening criteria, TBCCEDP will provide screening services, including clinical breast examinations, mammograms, pelvic examinations, and Pap tests. The TBCCEDP will also provide funds for post screening diagnostic services, such as surgical consultations and biopsy, to ensure that all women with abnormal results receive timely and adequate referrals. For those meeting the screening requirements the TBCCEDP will:

- Determine presumptive eligibility and fax the Presumptive Eligibility Form (HS-2768) to the local DHS office and a copy to the TennCare Medicaid Policy Unit #615-313-6639, Attention: Teresa McCathern
- Pay for screening and diagnostic services

DHS Responsibility

For applicants who have not already been approved for presumptive eligibility, DHS is responsible for informing applicants of the BCC category and explaining the presumptive eligibility process. The client must be informed of where they may be screened. DHS will process any application received for other Medicaid categories, but a woman may be able to be approved for presumptive eligibility through TBCCDEP which will give an initial 45 days of coverage.

TBCCEDP will fax the presumptive eligibility form HS-2678 to the correct DHS county office and instruct the participant to go to her local DHS office to apply for TennCare Medicaid. The participant will also be instructed to take her copy of the PE form.

- TennCare Medicaid Policy Unit state office staff will add the presumptive eligibility coverage to the TennCare system. Presumptive eligibility begins on the date the TBCCEDP determines that the woman appears to have breast/cervical cancer or pre-cancerous conditions.
- The DHS state office personnel will use the presumptive form HS-2768 to verify the individual's diagnosis and check the TennCare system for any already existing coverage.
- The DHS caseworker will mail the applicant a DHS application form, HS-1069, along with a verification checklist and an appointment to apply. Before BCC coverage can be approved for ongoing coverage, she must be screened for other TennCare Medicaid categories.
- Explain during the interview, if the applicant has been diagnosed with cancer by the TBCCEDP, that a copy of her treatment plan will be requested in order for TennCare Medicaid to continue after the end of the 45 day presumptive period.
- When an application is received from the client, the DHS caseworker will process for other Medicaid categories.
- The DHS caseworker must notify the TennCare Medicaid Policy Unit of the disposition of the TennCare Medicaid application, whether approved or denied.
- If no application is received by the 44th day of the presumptive eligibility period, the DHS caseworker must notify the TennCare Medicaid Policy Unit. Presumptive coverage must end on day 45 if the client has not followed through with an application at DHS.

Effective Date of Eligibility when an application for Breast or Cervical Cancer is filed at DHS prior to screening at the Department of Health (DOH)

- If during an interview for Medicaid, the individual states she has breast or cervical cancer, the DHS caseworker must document that fact in ACCENT,
- The DHS caseworker must refer the applicant or recipient losing her Medicaid and who does not qualify in any open Medicaid category, to DOH.

- The DHS caseworker must explain to the applicant/recipient that if it is determined by DOH that she has breast, cervical cancer or a pre-cancerous condition, coverage may begin the date the application is filed at DHS.
- The DHS caseworker must e-mail Joyce Neal (Joyce.Neal@state.tn.us) immediately, informing her of the date the referral was made to DOH and the DHS application date. The e-mail must have the applicant-/recipient's name, Social Security number and ACCENT case number.
- Medicaid Policy State Office staff will create and monitor a DOH BCC referral spread sheet.
- Upon receipt of the DOH BCC Presumptive eligibility approval, the BCC individual will be compared to the BCC DOH referral spread sheet. If the PE approval segment is within 10 days of the DHS referral date, the PE will begin with the DHS application date.
- Medicaid Policy State Office staff will continue to enter the PE date.

In examples one (1) and two (2) below, the individuals have filed an application for Medicaid at DHS and were screened by DOH within 10 days of the DHS referral to DOH. In both examples, the PE begins with the DHS application date and the individuals will receive more than 45 days presumptive coverage. In example three (3), the individual has filed an application for Medicaid and referred to DOH but is not screened within 10 days and her PE period will be the date determined by DOH.

Example # 1: Client files an application at DHS on June 1, 2008. She is interviewed on June 4, 2008, and is referred to DOH on June 4, 2008. The DHS caseworker sends an e-mail to Joyce Neal. The client is screened by DOH on June 9, 2008, and is given a 45 day PE period from June 9, 2008 to July 24, 2008. Since she went to DOH within 10 days of the DHS referral date, her PE period will begin June 1, 2008--her DHS application date. Her PE will end on June 24, 2008, as originally determined by DOH.

Example #2: Using the same scenario above, client misses her DHS appointment on June 4, 2008, and her rescheduled DHS appointment is June 11, 2008. She is referred to DOH on June 11, 2008, and the DHS caseworker sends an e-mail to Joyce Neal. The client is screened by DOH on June 15, 2008, and approved for PE from June 15, 2008 to July 30, 2008. Since she went to DOH within 10 days of the DHS referral date, her PE coverage will begin on June 1, 2008--her DHS application date. Her PE will end July 30, 2008, as originally determined by DOH.

If the applicant **does not** apply for PE at DOH within 10 days of the DHS referral date, the PE period as determined by DOH will **not** be adjusted and will be the date determined by DOH.

Example #3: Using the same scenario above, client misses her DHS appointment on June 4, 2008 and she is rescheduled for June 11, 2008. She is referred to DOH on June 11, 2008, and the DHS caseworker sends an e-mail to Joyce Neal. The client is screened by DOH on June 25, 2008, and approved for PE from June 25, 2008 to August 10, 2008. Since she was not screened by DOH within 10 days of the DHS referral date, her PE coverage will **not** begin on June 1, 2008--her DHS application date. Her PE will be June 25, 2008 to August 10, 2008, as originally determined by DOH.

Processing the PE Form for Initial Coverage and Establishing Ongoing Coverage

Currently, the TennCare Medicaid Policy Unit of the DHS state office is responsible for processing presumptive eligibility coverage dates. The Medicaid Policy Unit also determines ongoing coverage, if the client remains eligible. Following are the responsibilities of the DHS state office unit:

- Once form HS-2768 is received (FAXED) presumptive coverage is processed so coverage can begin.

- Validate that the coverage segment correctly transmits and displays on the TennCare System.

- Maintain all presumptive forms and any correspondence regarding an applicant or recipient in the TennCare Medicaid Policy Unit.

- Close the BCC Medicaid eligibility segment if the individual is determined TennCare Medicaid eligible in another category of Medicaid.

- If TennCare Medicaid is denied for all other categories, and the applicant has been diagnosed with breast/cervical cancer:

    - Request the county office to provide verification of the treatment plan.
    - Upon receipt of verification, continue eligibility in the BCC category.
    - If the condition is benign or she fails to provide verifications, this will result in case closure of the PE case.

- Once the oncologist determines the patient is cancer free or in remission, the BCC case will be closed. An application will be mailed with the closure notice, giving the patient an opportunity to apply for TennCare Medicaid in other categories.

Primary Screening Providers

The actual screening for Breast/Cervical Cancer or Pre-cancerous condition will be performed by the providers listed below:

Hardeman County Community Health Center
ATTN: Mary Heinzen
629 Nuckolls Rd.
Bolivar, TN 38008
(731) 659-3114
FAX: (731) 659-3131

Alton Park and Dodson Av.
Community Health Center, Inc.
ATTN: Debra Hale
1200 Dodson Av.
Chattanooga, TN 37406
(423) 778-2800
FAX: (423) 778-2822

Memorial North Shore Health Center
ATTN: Rosalie Whitaker
208 Minor St.
Chattanooga, TN 37405
(423) 756-1506
FAX: (423) 756-1909

The Greenlaw Center
ATTN: Frosan Blayde
278 Greenlaw Av.
Memphis, TN 38105
(901) 521-8222

Meharry OB/GYN Clinic
ATTN: Shelia Johnson
1005 D. B. Todd Blvd
Nashville, TN 37208
(615) 327-5637
FAX: (615) 327-5541

Rossville Health Center
ATTN: Brenda Jeffries
P. O. Box 249
Rossville, TN 38066
(901) 853-2291

Faith Family Medical Clinic
ATTN: Sheree Keith
326 21st Av. North
Nashville, TN 37203
(615) 341-0808
FAX: (615) 341-0881

East Jackson Family Medical Center
ATTN: Doris Maclin
635 Lexington Av.
Jackson, TN 38301
(731) 425-7900
FAX: (731) 425-7910

Methodist Teaching Practice
ATTN: Connie Blair
1325 Eastmoreland Suite 101
Memphis, TN 38104
(901) 726-8785
FAX: (901) 726-2119

Matthew Walker Health Center
ATTN: Bertha Hall
1501 Herman St.
Nashville, TN 37208
(615) 329-1863
FAX: (615) 340-1280

Rutherford County Primary Care and Hope Clinic
ATTN: Shane Culver
745 South Church St., Bldg 6, Suite 601
Murfreesboro, TN 37130
(615) 893-9390
FAX: (615) 893-4162

Refugee Medical Assistance (RMA) Program

Medical Services for any refugee regardless of national origin, and aliens treated as refugees such as parolees, asylees, and trafficking victims are available to those who qualify under the Refugee Act of 1980. Refugees from any country who have fled or cannot return to their country of nationality because of persecution or fear of persecution on account of race, religion, or political opinion and who have been granted parole status in the U.S. and individuals granted asylum (not applicants for asylum) may be eligible for benefits under RMA. Recently Iraqi and Afghan aliens were granted Special immigrant status as described in section 101(a)(27) of the Immigration and nationality Act (INA) entitling them to the same resettlement services and entitlement programs available to refugees admitted under section 207. The following may be used as evidence:

- Iraqi or Afghan passport with an immigrant visa stamp noting that the individual has been admitted under IV (Immigrant Visa) Category SI1, SQ1, SI2, SQ2, SI3, SQ3, and have DHS stamp notation on passport or I-94 showing date of entry.
- DHS Form I-551 (green card) showing Iraqi or Afghan nationality (or Iraqi or Afghan passport), with an IV (immigrant visa) code of SI6, SQ6, SI7, SI9, or SQ9.

Refugees/Asylees can be identified by the Immigration and Naturalization Services (INS) Form I-94 approved under section 212(d)(5); 207 or 203 (a)(7) with terms: REFUGEE; initials OCE; or ASYLUM GRANTED entered on the lower right-hand quadrant of the form I-94. (See the Chapter on Citizenship and Residency for specific information regarding the verification of parole status.) Medical Services will be provided in the same manner and to the same extent as under the State's Title XIX Program, including EPSDT referrals for refugee/entrant children.

A refugee/entrant does not have to be: aged, blind or disabled; or a child under age 21; or a family with children; or a child in a special living arrangement to be eligible for medical assistance. Financial need and refugee/entrant status are the only eligibility criteria for refuges/entrants under RMA. Eligibility is determined under this program when the refugee/entrant is NOT technically eligible for Families First or TennCare Medicaid programs.

The appropriate Medically Needy Income Standard (MNIS) and resource limits are used in determining eligibility for refugee/entrant applicants/recipients. Information can be found in the Income, Treatment of Income, and Resources Chapters.

Only income and resources actually available to the refugee/entrant will be considered in determining eligibility. Income and resources of sponsors, including in-kind services and shelter provided by sponsors, are not considered in determining a refugee/entrant's eligibility.

Budget procedures are the same as for other Medically Needy individuals/families and can include exceptional and spend down procedures for children under 21 and pregnant adults. Pregnant woman and children of a specified age may qualify under the PLIS categories as outlined in that Chapter.

This section of the manual outlines county and state office responsibilities for determining eligibility and authorizing medical assistance for refugees/entrants who do not qualify for regular Families First or Medical Assistance. Please see the Families First Handbook and the chapters in this Manual for determining eligibility for regular FF and MA, respectively.

Application Process

TennCare Medicaid coverage is authorized manually and processed through the Families First Policy Unit in the state office. When an application is made by a refugee/entrant, enter the case name as it appears on the INS Form I-94 and date of application on manual control lists developed for that purpose. Do NOT register these as applications on the data base.

Use the HS-0169 Application for Assistance. Consider any application filed to be a request for both financial and medical assistance unless only TennCare Medicaid is requested. Use the Application Workbook, HS-1809 and any other appropriate forms as needed for case recording. Calculate a budget on each determination.

The case file should include:

- Name and address of the sponsor and the resettlement agency
- Employment status of family members
- Which family members speak English or name of interpreter, if needed
- Social Security numbers for each person applying
- Month and year of entry into the U.S.
- Alien registration numbers from I-94 cards
- Photocopy of all INS documents, including front and back of the I-94 card.

TennCare Medicaid benefits will be authorized for no more than 8 months from the date of entry or parole, once eligibility is determined. This is the maximum authorization period for RMA.

REFUGEE MATCHING GRANT PROGRAM

The Refugee Matching Grant Program, initiated by Congress in 1979, became effective with the Refugee Act of 1980. It was developed to provide an alternative to public assistance by bringing together federal and community resources to serve newly arriving refugees, asylees, Cuban/Haitian entrants and trafficking victims.

Eligible adults may receive $200 per month and eligible children $10 each per week in match grant funds for a maximum of 180 days. Participating sponsoring agencies, such as World Relief and Catholic Charities, match the Federal Office of Refugee Resettlement grant with cash and in-kind contributions. Sponsoring agencies will discontinue the match grant if the assistance group begins receiving Refugee Cash Assistance or Families First.

Workers who interview newly arriving refugees, asylees, Cuban/Haitian entrants and trafficking victims are to ask if a match grant is being received. If the answer is yes, verify the amount received, when it was received, and when the grant will be exhausted.

Counting the match grant

- Count any grant monies in the Families First and Refugee Cash Assistance budget.
- Do not count the match grant when determining Refugee Medical Assistance.

- Count the match grant in determining Food Stamp eligibility and eligibility for TennCare Medicaid categories.

Continuing Responsibilities

- A complete redetermination must be made every six months. Manual controls must be used to keep up with the review date.

- If a change occurs at the time of review, such as an address change or a change in the aid group, complete a revised TWISS authorization form and send it in for processing.

- TennCare Medicaid benefits will automatically terminate at the end of the maximum authorization period unless a closure is submitted by the caseworker before the maximum authorization period ends.

- Schedule a Special Action as needed when a known factor of eligibility is likely to change. Manual controls will be needed to keep up with Special Actions due.

- The refugee is responsible for reporting any changes in his/her circumstances which might affect eligibility, such as, address, living arrangement, income and resources. If a recipient's circumstances change during the maximum authorization period, send a change form to the Families First Policy Unit, State Office, reflecting the change.

Completion of the Case Data Form

Use the Public Assistance Case Data Form 5005 (HS-0421) to obtain case and individual ID numbers and to authorize TennCare Medicaid coverage. Submit the case data form at the time of approval/closure (within the 8 month authorization period) and to report any data changes to the Families First Policy Unit in the state office.

Instructions for Completion of the Public Assistance Case Data Form 5005

Print the following information in red lettering at the top of the Public Assistance Case Data form:

- The word REFUGEE;

- The Date of Entry the refugee arrived in the U.S.;

- The agency sponsoring the refugee;

- The country the refugee is from; and

- The alien registration numbers for all refugee assistance group members.

Enter the following information in Sections A through F:

- Section A

Date of transaction;
Type of action (check only one box);
Data entered; and
Caseworker number.
DO NOT complete the Case ID number. The State Office will assign this number.

- **Section B**

  Complete address; and County number

- **Section C**

  Case information including Category;
  Caseload;
  Application date;
  Approval/rejection date; and
  Approval/rejection reason.

- **Section D**

  First, middle, and last name;
  Date of birth;
  Sex
  Race
  Relationship
  Employment; and
  TennCare Medicaid eligibility begin date and eligibility end date. Do not approve for more than 8 months from the date of entry into the United States. The month of entry counts as the first month, even if the refugee arrives on the last day of the month. For example, if a refugee arrives on May 31, 2004, May is counted as the first month, and the ending date for Refugee Cash Assistance and/or Refugee Medical Assistance is December 2004.
  Do not enter Recipient ID numbers. These numbers are assigned by the State Office.

- **Section E**

  Enter a complete budget in Section E on all cash assistance cases.

- **Section F**

  Enter Retro Cash budgets for cash approvals only.

  Enter the Case Name on the "CASE NAME" line.

  Sign and date the case data form and send both copies to the Families First Policy Unit in the State Office. All case actions must be received in the State Office five working days

prior to the last day of the month. When the transaction is processed, one copy of the case data form will be returned to the county office.

I**mportant:** Attach a copy of the INS form I-94 for each refugee named on the Public Assistance Case Data Form 5005.

Purpose of the Form 1495 (HS-0993)

Use the Authorization for Payment Form HS-0993 to authorize Refugee Cash Assistance. Submit the authorization for payment form at the time of approval for cash payment.

Instructions for Completion of Form 1495 (HS-0993)

Form 1495 (HS-0993) is used with each case data from to authorize payment for Refugee Cash Assistance. Use Form 1495 when cash assistance is being authorized for the first time or reauthorized after a period of ineligibility has existed. Only the original is to be submitted with the case data form. A carbon may be retained in the case record. Cash payments under the Refugee Cash Assistance Program can be authorized for a period not to exceed eight months from the date of entry (or date of parole).

Form 1495 must be signed by the caseworker and the Area Manager. The signature and date should agree with those on the case data form. Attach the Authorization for Payment form to the Case Data Form and submit to the FF Policy Unit in the state office.

Enter the following information on the Authorization for Payment form:

- Check the appropriate Indochinese, other Refugee, or Cuban-Haitian block in the upper left corner.
- Enter the Resettlement Agency or Sponsor.
- Enter the alien registration number in the upper right-hand corner on all initial approvals.
- Check First Authorization or Reapproval.
- Enter the Case Name, Number of Adults, and Number of Children.
- Enter the address.
- Enter the Payee, if different from the case name, and payee's address.
- Enter the Date of Entry into the United States, Effective Date of Cash Payment, and the Date Eligibility Ends in the appropriate spaces (not to exceed 8 months from the date of entry or parole).
- Enter the amount of Cash Payment per month.
- Enter any Retro payments and Retro payment months.

Changes

All changes within the 8-month authorization period are to be reported via the PA Case Data Form 5005. Check the DATA CHANGE box at the top of the form. Include all information that was submitted on the original PA Case Data Form, plus the CASE ID NUMBER and RECIPIENT ID NUMBER(S) that were assigned by the State. Write the changes in red in the appropriate box or at the top of the form if there is not a box.

Attach a short memo to **the PA Case Data Form explaining the action taken any time a change is submitted on a Refugee Assistance case.**

MEDICARE PRESCRIPTION DRUG PROGRAM

Policy Statement

Starting January 1, 2006, Medicare will offer insurance coverage for prescription drugs through Medicare prescription drug plans and other health plan options. Medicare's new prescription drug coverage will typically pay over half of the drug costs for an individual (next year) for a monthly premium. Insurance companies and other private companies will work with Medicare to provide a choice of plans that cover both brand name and generic drugs. To enroll, an individual must have Medicare Part A and/or Medicare Part B. The first opportunity to enroll will be from November 15, 2005 through May 15, 2006.

The Medicare-approved drug discount cards that became available in May 2004 enabled participants to get a discount on prescriptions. They work like other grocery store or pharmacy discount cards already being used by some individuals. The cards are offered as a transition step to assist individuals with Medicare to save money on prescription drug costs until Medicare prescription drug plans became available.

Medicare-approved drug discount cards allow saving on the costs of prescription drugs. An individual is eligible for a Medicare approved drug discount card if he/she has Medicare Part A and/or Part B and does not have other health insurance that covers out-patient prescription drugs, except a Medicare+Choice or a Medigap policy. An individual can sign up for one of these cards only until December 31, 2005.

There are 66 general Medicare-approved drug discount card sponsors providing discounts on the top 100 drugs used by people over age 65. To enroll, participants may review the discount drug list, drug prices, and the choice of pharmacies by calling 1-800-MEDICARE (1-800-633-4227). For TTY users, call 1-877-486-2048. Or individuals may access the website at www.medicare.gov.

Individuals may be able to get a $600 credit toward prescription costs if they have:

- Medicare Part A and/or Part B, and
- An annual income in 2005 which is no more than $12,919 ($1077 month) if single or no more than $17,320 ($1444 month) if married.

If an individual's annual income is below the level shown above, Medicare may pay the enrollment fee for the Medicare-approved drug discount card and provide up to a $600 credit toward most prescriptions. Depending on annual income, the participant will have to pay a 5% or 10% coinsurance for prescription drugs and will receive a lower cost for some drugs.

An individual will not qualify for the $600 credit if he/she receives one of the following types of insurance:

- Medicaid,
- TRICARE for Life (military health insurance overage)
- Employer group health plan or other health insurance coverage
- FEHBP (health insurance for Federal employees or retirees).

NOTE: In order to qualify for the full $600 credit, application must have been made by March 31, 2005. For those who apply after this date, the $600 credit will be prorated.

Individuals Eligible for the $600 Credit and TennCare Medicaid Policy

Low-Income Medicare beneficiaries who qualify for the $600 credit when enrolled in a Medicare-approved drug discount card or who purchase discounted drugs using the card cannot be penalized when applying for TennCare Medicaid. The Medicare Modernization Act (MMA) which allows individuals to qualify for $600 drug credit prohibits budgeting any portion of the $600 as income or a resource in determining eligibility for program benefits.

Under the new law, program benefits cannot be denied or delayed because an individual has a Medicare-approved discount drug card or has the $600 credit. Any discount received on a purchased drug, and any portion of the $600 credit used to purchase drugs must be treated as if the person had actually spent the money out of his/her own pocket when being evaluated for spend down. This means that a Medicare beneficiary who has a discount drug card does not have to spend the credit before Medicaid can be approved. It also means that we can allow, as a spend down expense, any drug purchased using a portion of the $600 credit. The full price of a drug purchased using the discount card will be used as a spend down expense. The applicant may be able to provide the pre-discount price from the pharmacy, or the eligibility counselor may contact the pharmacy for this information.

Please remember that individuals who are already eligible for Medicaid are not eligible for a Medicare-approved discount drug card. However, if someone who already has the Medicare Drug Discount Card or the $600 credit applies for Medicaid and is approved; they may remain eligible for the Drug Discount Card and keep any credit not used. They cannot use the credit until Medicaid ends, unless it is for drugs not covered by Medicaid.

Individuals may be receiving drug discounts or subsidies through health insurance or other programs. These discounts or subsidies not related to an approved Medicare Drug Discount Card may not be counted as spend down expenses.

Medicare Part D: Low Income Subsidy

The Medicare Modernization Act (MMA) of 2003 established a new voluntary Part D Prescription Drug Program which becomes effective January 1, 2006. The Centers for Medicare and Medicaid Services (CMS) has overall responsibility for the new drug program, and the Social Security Administration (SSA) is required to take applications and determine eligibility for the Low Income Subsidy (LIS) program.

This subsidy will reduce out-of-pocket costs paid by those Medicare Part D enrollees who have limited income (below 150% of the federal poverty level) and limited resources (up to $10,000.00 for individuals or up to $20,000.00 for a married couple).

SSA mailed letters and LIS applications to potential LIS individuals on May 2, 2005. The potential LIS individuals must be currently entitled to Medicare Part A and/or enrolled in Part B. The letters from SSA include this statement: "our records show you may be eligible to get extra help paying for your prescription drugs…". The letter advises the individual to complete the application and return it in the postage paid envelope provided. If completed and returned, the LIS applications will be received in a centralized SSA location and an LIS eligibility determination made.

Those who are deemed eligible are automatically eligible for LIS and do not need to apply. SSI recipients and QMB and SLMB recipients are considered "deemed" eligible.

There are six (6) different ways an individual can apply for the Low Income Subsidy:

- Receive an application in the mail from SSA. Complete and return the application in the postage paid envelope provided by SSA.

- Apply on-line at SSA website: www.socialsecurity.gov.

- Call SSA at 1-866-232-4032 or (TTY 1-800-325-0778).

- Visit local SSA field office.

- Attend an SSA sponsored outreach event. The events will include gatherings at senior centers, churches, retail stores and will also include brochures with applications placed in various community locations. They will be able to file an application at these events.

  File an application with the state Medicaid office (DHS offices in TN.)

  - Any DHS county office contacts regarding LIS will be directed to the DHS central office in Nashville at 1-866-207-5075. This is a toll free number.

  - Any LIS applications received by the county offices will be forwarded weekly to the local SSA office in business reply envelopes provided by SSA. The business reply envelopes will have the address of the SSA office that serves that county.

  - DHS' primary role is to make individuals aware of the information listed above in numbers 1-5. Eligibility for LIS will be determined by SSA.

SSA will mail notification of eligibility (eligible or ineligible). Those approved for LIS will be required to enroll in a Part D plan. If the enrollee does not select a plan, one will be selected for him/her. If determined to be ineligible, the individual can file an appeal with SSA.

GENERAL ADMINISTRATIVE PROCEDURES

Introduction

Most TennCare Medicaid cases are maintained in an electronic file. The TennCare Medicaid assistance group is a part of a case file for all the members of a common residence group. There may be multiple assistance groups in a single case. The application or re-application for assistance is completed on a single one-page application form for all types of assistance. Case numbers and individual recipient numbers are assigned electronically by the data base. The one-page paper application form that is signed by the applicant/recipient is maintained in the county office in an alphabetical file by month of application or reapplication.

The application and reapplication interviews are conducted in an on-line interactive process. The date of application/reapplication will always be the date the signed and dated application form is received in the county office. If the interview is conducted in a remote site, the date will be the date the caseworker receives the form. The electronic file contains responses to all interview questions and verifications of all eligibility components.

Applications by Department Employees and Their Relatives

The Field Supervisor, Area Manager, the District Family Assistance Director, or the District Administrator must be made aware as appropriate of applications, reapplications, or changes to assistance groups containing an employee or a relative of an employee.

Applications made by an employee or a relative of an employee of the Department should be processed by a county or district supervisor.

The case should be maintained in a "Confidential Caseload" on the data base.

The county office should maintain a plan to insure that confidential procedures are followed for employee and relative applications, reapplications, and changes.

Confidentiality Standards

Legal Base: 42C.F.R. 431.300ff
Subpart F

Federal and State laws provide safeguards that restrict the use or disclosure of information concerning the applicant/recipient to purposes directly connected with the

administration of the Medicaid program. Such purposes include establishing eligibility, determining the amount of medical assistance, providing services to the recipient and conducting or assisting in an investigation, prosecution or civil criminal proceedings related to program administration.

The Health Insurance Portability and Accountability Act (HIPPA) of 1996

Public Law 104-191 establishes federal rules to protect the privacy and security of protected health information. The privacy rule protects electronic records, paper records and oral communication. It gives patients privacy rights regarding access to and use of their medical records.

These polices apply to all requests for information from outside sources including governmental bodies, the courts or law enforcement officials.

Information Subject to Restricted Use:

- The individual's name and address
- Medical services provided
- Agency evaluation of personal information
- Social and economic conditions or circumstances
- Medical information including diagnosis and past history of disease or disability

Requests for Information by Outside Parties Regarding Eligibility Of Clients And Related Medical Information

Frequently, DHS staff is contacted by outside parties, including family members, family friends and attorneys or their staff who represent clients of the Department, to request information about particular clients' TennCare or Medicaid cases. The ability to freely answer those questions and provide information to third parties requesting information about a client's TennCare or Medicaid case is limited by the Health Insurance Portability and Accountability Act (HIPAA), a federal law that restricts to whom we can provide information about clients' eligibility for TennCare or Medicaid services. This law also restricts the Department from giving third parties information that DHS may have obtained about clients' medical conditions, personally identifiable health information, and medical bills used to determine eligibility for these programs.

In order to ensure compliance with HIPAA, please utilize the following policies and procedures.

When contacted by an attorney or someone from an attorney's office such as a paralegal or clerical staff about the Medicaid or TennCare case of a particular client.

- Tell the person that it is the policy of the Department to refer all attorney contacts about clients' Medicaid and TennCare cases to the Department's General Counsel's office.

- Take the person's name and number, and tell the person that someone from the General Counsel's office will contact him or her.

- Immediately email the contact information to Valerie Webb, the Department's Deputy General Counsel, valerie.webb@state.tn.us.

- Call Valerie Webb at (615) 313-5840 to confirm her receipt of this information. **DO NOT** discuss the client's case with the requesting party or provide the person with **ANY** information (written or otherwise) about the client's case unless otherwise notified by her or other Department of Human Services legal staff.

*When contacted by any other third party (including a person who claims to be a friend or relative of the client) you may **NOT** discuss the client's status or case with the third person unless:*

- If the client is present, discuss the information with the third party if the client specifically consents to the discussion;

- If the information request is received over the telephone, ask the requesting party if the client is present. If the client is present, please have the third party put the client on the phone. Ask the client a question to confirm the client's identity, and then ask the client if she consents to the discussion of her TennCare or Medicaid case with the requesting party. Only discuss the client's case with the requesting party if the client consents;

- If the information request is received over the telephone and the client is not present with the requesting party, tell the requesting party that federal law prohibits discussion of the client's case with the requesting party unless there is a written consent from the client, unless the circumstances mentioned above are applicable. Offer to mail or fax the requesting party or the client a blank authorization form that the client can complete, execute and mail or fax back to DHS. The authorization form is available in Shared Base documents. Once the completed authorization signed by the client is received, discuss the client's TennCare/Medicaid case with the person(s) listed on the form as being authorized to receive the information.

Note the following regarding authorization forms that may be received:

- If a signed authorization form is received that is different from the form in Shared Base documents, please forward it to the DHS HIPAA compliance officer for approval. Fax the form to the HIPPA compliance officer at (615) 741-4165. Please also call (615) 313-4748 to confirm receipt of the authorization. DO NOT share any information with a requesting party until approval of the authorization is received.

- In order to be valid, the authorization form MUST be completely filled out. A partially completed form is NOT a valid authorization. The authorization must also contain an expiration date. Always check the authorization date on the form to make sure the authorization has not expired. If you have any questions regarding the validity of an authorization, please contact the DHS HIPAA compliance officer at the number listed above. Please resolve any questions before releasing any information to a requesting party.

- Please make a note that you have received a valid authorization approved by the DHS HIPAA compliance officer in the electronic case record, describing the specific information authorized to be released as listed in the authorization, to whom the information can be released per the authorization, any information provided to third parties, and to whom the information was provided. This is very important because others in the county offices, service centers, state office, and appeals and hearings unit must be able to look at the client's electronic case record and know that an authorization has been received, to whom information can be released, and what information can be released. Please also note the expiration date of the authorization in the electronic running record.

- A file of all authorizations received in the county office must be maintained with a copy of each authorization forwarded to Natasha Webster.

RIGHTS AND RESPONSIBILITIES

Policy Statement

The Tennessee Department of Human Services (DHS), at all administrative levels, will not discriminate against any applicant, participant, or employee in any program aspect, for reasons of age, race, color, sex, disability, religious creed, national origin, or political belief.

Federal Non-Discrimination Laws

Title VI of the Civil Rights Act of 1964 – prohibits discrimination on the basis of race, color, or national origin in any program or activity that receives federal funds or other federal financial assistance.

Title VII of the Civil Rights Act of 1964 – prohibits private, state, and local government employers with 15 or more employees, and employment agencies from discriminating on the basis of race, color, sex (including pregnancy), religion or national origin in all aspects of an employment relationship. This includes hiring, discharge, compensation, assignments, and other terms, conditions, and privileges of employment.

Section 504 of the Rehabilitation Act of 1973 – prohibits discrimination on the basis of disability by employers and organizations that receive federal financial assistance.

The Americans with Disabilities Act of 1990 (ADA) – prohibits discrimination on the basis of disability by both public and private entities, whether or not they receive federal financial assistance.

The Age Discrimination Act of 1975 (ADEA) – prohibits discrimination on the basis of age in programs or activities receiving federal financial assistance.

Title IX of the Education Amendments of 1972 – prohibits discrimination on the basis of sex in educational programs and activities that receive or benefit from federal financial assistance.

The Equal Pay Act (EPA) – requires payment of equal wages to men and women performing substantially the same work unless the pay discrepancy is based on a seniority or merit system (a system that measures quantity or quality of production, or a factor other than sex). The EPA applies to employers of any size.
Other related regulations include:

Titles VII and VIII of the Public Health Service Act – bars sex discrimination in admissions to health training programs.
Hill Burton Community Service Assurance Act – requires that hospitals or other health care facilities assisted under the Act provide services to persons residing in the community without discrimination based on race, color, national origin, or method of payment. Hill Burton hospitals may not refuse emergency services because of a person's inability to pay.

Drug Abuse Office and Treatment Act of 1972 – hospitals may not refuse to admit or treat anyone needing emergency care solely because that person is dependent on or addicted to drugs.

Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 – hospitals may not discriminate in admissions or treatment against alcoholics solely because of alcohol abuse.

Multi-Ethnic Placement Act of 1994 (MEPA) – prohibits placement of children for adoption and foster care on the basis of race.

Coverage by Federal Nondiscrimination Laws

The **nondiscrimination statutes** listed above prohibit discrimination on the basis of race, color, national origin, age, and disability in programs or activities that receive or benefit from federal financial assistance. Discrimination on the basis of disability is prohibited in all programs, services, or activities of public entities. ADA (Americans with Disabilities Act) coverage does not depend on the receipt of federal funds.

The **employment discrimination statutes** prohibit discrimination on the basis of race, color, religion, national origin, citizenship status and unfair documentary practices regarding employment verification, sex, age, and disability in private and public sector employment. Depending on the circumstances, the Department may be subject to coverage under both the nondiscrimination statutes and the employment discrimination statutes.

FAMILY ASSISTANCE ACCOMODATION REQUIREMENTS

DHS is required to provide reasonable accommodations to applicants/recipients to ensure that they have equal access to benefits and services. *"Reasonable accommodation"* includes, but is not limited to:

- modifying existing facilities to make them accessible;
- acquiring or modifying equipment;
- providing readers or sign language interpreters.

Accommodations are designed and granted on a case-by-case basis to address special needs and to guarantee that every applicant/recipient has full access to Family Assistance Programs.

At each client contact, ensure that the individual has all of the information and assistance from the Department that is needed to complete the application, interview, or other action, prior to ending the conversation. If an accommodation is requested but it is questionable whether or not the request can or should be fulfilled, contact the Area Manager or FS1 for a final decision.

Accommodations should be offered when:

- the client requests accommodations based on a disability or impairment that will prevent access to our services;

- the DHS staff member (counselor, front desk staff, etc.) is concerned that the individual may not understand the application, verification or recertification instructions;

- the DHS staff member is concerned that the individual may not complete the application or recertification review without these accommodations;

- the program's policies dictate that a waiver from the office interview is appropriate; or

- other circumstances or information lead DHS staff to think that accommodations are needed.

- All clients must have access to our standard services. While accommodations must be offered to those in need of them, these specialized services are a client option, not a requirement.

County Office Accommodations Procedures

Written procedures must be in place in each county to ensure that all staff who directly serves clients is aware of how to arrange for accommodations and know who must be consulted to make these arrangements.

Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency (LEP)

In order to ensure compliance with Title VI, DHS must take steps to ensure that LEP persons who apply for or receive TennCare Medicaid or TennCare Standard have meaningful access to those programs. The most important step in meeting this obligation is to provide the language assistance necessary to ensure such access, at no cost to the LEP person.

The type of language assistance provided depends on a variety of factors, including:

- the size of the organization providing the service;
- the size of the LEP population it serves;
- the nature of the program or service;
- the objectives of the program;
- the total resources available to the organization providing the service;
- the frequency with which particular languages are encountered; and
- the frequency with which LEP persons come into contact with the program.

The key to providing meaningful access for LEP persons is to ensure that the Department and the LEP person can communicate effectively. The steps taken must ensure that the LEP person:

- is given adequate information;
- is able to understand the services and benefits available;
- is able to receive those benefits and services for which he/she is eligible; and

- is able to effectively communicate the relevant circumstances of his/her situation to the Department.

In order to ensure that persons are not excluded from equal program participation due to limited English proficiency (LEP), the Department must provide trained and competent interpreters and other oral language assistance services to accommodate our LEP clients. We may:

- hire bilingual staff;
- hire staff interpreters;
- use volunteer staff interpreters;
- use volunteer community interpreters;
- contract with an outside interpreter service; or
- use a telephone interpreter service.

Friends and family members may be used as interpreters at the request of the LEP client provided the use of such a person would not compromise the effectiveness of the services, violate confidentiality, and the client is first advised that a free interpreter is available. The LEP client's declination of the offer of free interpreter services must be documented. Also suggest that a trained interpreter (in addition to the friend/family member) sit in during the interview to ensure reliable and correct interpretation of information. Minor children cannot be used as interpreters.

Written materials that are routinely provided in English to applicants, recipients, and the public must be made available in regularly encountered languages other than English. We must ensure that communication tools are provided to LEP clients. The following is a list of the minimum requirements for written documents that should be in the language of the client:

- any documents that have to be signed;
- documents that describe the eligibility requirements to participate in a program;
- notifications of changes in status;
- documents informing clients of rights; and
- communications informing clients of meetings and reviews for the purpose of recertification.

OCR (Office for Civil Rights) will consider the Department to be in compliance with its Title VI obligation to provide written materials in non-English languages if for:

- **LEP language groups that constitute ten percent or 3,000** (whichever is smaller) of a service area, the Department provides translated written materials, including vital documents, for each eligible person to be served or likely to be directly affected by the TennCare Medicaid program;

- **LEP language groups that constitute five percent or 1,000** (whichever is smaller) of a service area, the Department ensures that, at a minimum, vital

documents are translated into the appropriate non-English languages for each eligible person to be served or likely to be directly affected by the TennCare Medicaid program;

- **LEP language groups that constitute fewer than 100 persons** in a service area, the Department does not translate written materials but provides written notice in the primary language of the LEP language group of the right to receive competent oral translation of written materials for each eligible person to be served or likely to be directly affected by the TennCare Medicaid program.

  The "service area" is defined as the county served by each DHS office. The LEP population in each county would determine how individual offices apply the Title VI directives.

Title VI Prohibition on Discriminatory Conduct In Federally Funded Programs and Activities

DHS may not discriminate against people on the basis of race, color, national origin, disability, or age in how we administer our programs or activities.

DHS may not exclude or deny benefits to persons based on their race, color, national origin, disability, or age, or on the basis of sex in education programs.

EXAMPLES:

- DHS caseworkers may not reject an applicant for benefits because he/she is or appears to be an African-American, Hispanic, Asian, American Indian, Alaskan Native, or a member of another racial or ethnic group. If an applicant declares that he/she is a U.S. citizen, no further verification is required unless there is reason to question the statement.

- Caseworkers may not reject an application based on the assumption that a person with a foreign-sounding last name is not a citizen and therefore not eligible.

- DHS caseworkers may NOT deny benefits to persons who are not fluent in English because they assume persons who are, or appear to be, from other countries and are not English proficient, are not eligible for such benefits.

DHS **may not impose different standards or procedures to determine who may receive benefits** on the basis of race, color, national origin, disability, or age, or on the basis of sex in education programs.

EXAMPLES:

- A DHS caseworker may not accept a self declaration of qualified immigration status requiring verification from applicants who appear to be of African origin,

yet require all immigrants from Spanish speaking nations to submit INS documentation because of an assumption that these applicants are illegal aliens.

DHS personnel may not report suspected illegal aliens to the INS on the basis of race, color, or national origin. Independent evidence supporting illegal alien status is necessary.

An employee of a contractor hired by the state may not delay a review of referrals from older individuals until after she evaluates referrals from younger persons.

DHS **may not provide different benefits** to persons on the basis of their race, color, national origin, disability, age, or on the basis of sex in education programs.

Discriminatory Conduct on the Basis of Handicap/Disability That Is Prohibited in Programs and Services

DHS may not discriminate against any qualified individual with a disability in providing services or administering any program or activity, whether or not the program receives federal financial assistance. In general, an individual with a disability is "qualified" if that person meets the essential eligibility requirements for receipt of services or participation in the program or activity. DHS may not refuse to allow a person with a disability to participate because the person has a disability. We must eliminate unnecessary eligibility standards or rules that deny an individual with a disability an equal opportunity to participate. DHS may not harass a program participant or applicant based on a disability.

DHS is required to make reasonable modifications in policies, practices, and procedures that deny equal access to individuals with disabilities, unless a fundamental alteration in the program would result.

DHS must ensure that programs and services are provided in an integrated setting, unless separate or different measures are necessary to ensure equal opportunity for individuals with disabilities. Programs that provide special benefits to people with disabilities are permitted, but people with disabilities cannot be compelled to participate in those programs.

EXAMPLES:

- A county DHS office may offer an alternate site for an eligibility interview at the Community Mental Health Center for those with mental disabilities. However, the office may not require people with mental disabilities to go to an alternate site for an interview.

- A county DHS office may not require people with HIV to be served in a separate room from the other participants.

- A county vocational training program may offer special training opportunities for people with vision impairments. However, it may not require people with impairments to participate in the special program or refuse to permit them to participate in courses open to other program participants.

- DHS must ensure effective communication with individuals who have hearing, speech, or vision impairments. Programs must provide auxiliary aids and services when necessary to ensure effective communication. However, they are not required to provide auxiliary aids that will result in undue financial and administrative burdens. Examples of auxiliary aids are Braille material, sign language interpreters, readers, or text telephones (TTYs).

- DHS may not exclude individuals with disabilities from programs and activities because buildings are inaccessible. For example, a DHS office that is located on the second floor of a building that has no elevator may make its services available to an applicant who uses a wheelchair by meeting with that applicant in an accessible ground floor office.

Accommodations Procedures

Waiver of office interview for applicants/recipients

If the client has named an authorized representative for the AG, the representative can come to the office in lieu of the AG. The authorized representative may answer basic questions needed for eligibility determination.

The office interview must be waived upon request by any AG which is unable to appoint an authorized representative and:

- has no AG members able to come to the county office because they are 60 years of age or older or are handicapped/disabled;

- lives in an extremely remote location;

- has no AG member able to come to the county office because of transportation difficulties or similar hardships which the county determines, on a case-by-case basis, warrants a waiver of the office interview. These hardship conditions include, but are not limited to:

    - illness;
    - care of a household member;
    - prolonged severe weather;
    - hardship associated with living in a rural area; and/or
    - employment or training hours that prevent an applicant/recipient from participating in a face-to-face interview.

NOTE: If needed, the county office should try to accommodate working/training hours by scheduling appointments outside of traditional business hours.

Telephone Interviews

The county office may offer a telephone interview in lieu of a face-to-face interview for an AG for whom the face-to-face interview has been waived.

Out-of-office interviews

For those clients who are unable to come to the office or participate in a phone interview, interviews may be held in a mutually agreed-upon site (e.g. Community Mental Health Center, client's workplace, DHS satellite offices, community agencies, or other locations).

Alternate interview examples

- When a client is hospitalized, a telephone interview or an authorized representative interview should be offered;
- A home-bound disabled client who is unable to be served through a telephone interview or authorized representative should be offered a home visit;
- If a handicapped/disabled client indicates that he/she needs a home visit because of transportation problems, consult with the Area Manager for additional guidance as to whether the accommodation should be made. A home visit is not necessarily the mandated accommodation if other arrangements, e.g. telephone interview or alternate transportation, can be made.

Filing Discrimination Complaints

Any individual or his/her representative may file a discrimination complaint with the County, District, or State Office of the Department of Human Services, or with the U. S. Department of Health and Human Services. Complaints may also be filed with the Tennessee Human Rights Commission. A complaint may be filed at both the state and the federal levels, separately or concurrently, at any time during the process. The complaint may concern discriminatory practices or actions on the part of DHS. The complaint may also involve practices or actions by other agency related institutions, organizations, contractors, medical care vendors or practitioners that participate in the TennCare Medicaid program by providing aid, care, or services. DHS will investigate each complaint promptly to determine whether or not it is justified and, if justified, what corrective action is appropriate. Following the receipt of a complaint, the following actions should be taken:

- **Instruct the complainant to submit the complaint in writing**, preferably on Form HS-2631, *Complaint Under Civil Rights Act of 1964.* The complainant, his/her representative, or a Title VI Coordinator may complete the form. A verbal complaint may be taken, but must subsequently be written up on Form HS-2631. Unless a complaint is already being filed at the state or federal level, it is preferable that all complaints be filed initially at the local level within thirty (30) days of the alleged discriminatory act.

- If the complainant is not willing to complete the official form, he/she may write a letter setting forth his/her grievance and a staff member will complete the form. If the complainant refuses to file an official written complaint, record the complaint in the electronic case record.

- Record the complaint in the Title VI Complaint Log. List complainant identification and type/status of the complaint.

- Send the original copy of the complaint to the DHS Title VI Coordinator located at the DHS state office in Nashville (include all pertinent information). Give a copy of the complaint to the complainant and retain one for local files. The local Title VI Coordinator must notify the DHS Title VI Coordinator immediately when any complaint is filed.

- Mail a letter to the complainant acknowledging receipt of the complaint within five (5) calendar days of the date that the complaint was received.

- Conduct a fact-finding investigation within thirty (30) calendar days of the receipt of the complaint. The local Title VI Coordinator is responsible for this initial investigation. When the complaint applies to discriminatory actions on the part of contracting agencies, individuals, or institutions from which assistance or service is purchased or secured by the Department, the complainant will be interviewed to secure as much information as possible. The interview will examine the nature of the complaint, the precipitating circumstances, and identify the date the alleged act occurred.

- Report investigation findings to Department management within five (5) days of completion of the investigation. If the report includes a finding of violation of Title VI, include any proposed remedial action in the *Report of Investigation*, Form HS-2632.

- Give the written findings to the complainant within five (5) calendar days after the above report is completed. At this time, inform the complainant of his/her right to appeal at the state or federal level if there is disagreement with the investigation findings or the proposed remedial action (include appeal form and instructions for filing).

Filing an Appeal

Instruct the complainant to complete Form HS-2634, *Appeal from Finding.* The local Title VI Coordinator must forward a copy of the complaint, the findings, the proposed action, and the request for an appeal to the DHS Title VI Coordinator within ten (10) calendar days after the date of the appeal. Forward the form to the Tennessee Human Rights Commission (THRC) or the complainant may mail the form directly.

Tennessee Human Rights Commission
530 Church Street, Suite 400
Nashville, TN 37243-0745
Phone: (615) 741-5825

Complaints for TennCare Medicaid filed with federal agencies should be sent to:

U.S. Department of Health and Human Services
Office of Civil Rights
Atlanta Federal Center
61 Forsyth St. S. W., Suite 3B70
Atlanta, GA 30303
Phone: 1-800-368-1019

Public Notification of Nondiscrimination Compliance

The Civil Rights pamphlet will be given to each applicant/recipient at each application and review. The application form will contain information about rights and responsibilities.

All Tennessee Department of Human Services offices will permanently display the nondiscrimination poster provided by USDA, Food and Nutrition Service.

The Department will ensure that applicants/recipients and other low-income families/individuals have access to information regarding nondiscrimination statutes and policies, complaint procedures, and the rights of participants within 10 days of the date of a request for such information.

Availability of Information:

The following will be available to all staff involved in eligibility determination for TennCare Medicaid benefits:

- Tennessee Family Assistance Plan of Operation (includes waiver information);
- Federal Procedures;

- Tennessee Department of Human Services TennCare Medicaid Policy Manual; and

- Supplemental instructions (bulletins and memos) issued for use in serving households applying for TennCare Medicaid.

These program guides will be maintained in the county and State Office of the Department of Human Services for examination by the public on regular workdays during regular office hours.

Copies of the TennCare Medicaid Policy Manual are made available to public custodians. Public custodians are those who:

- request the manual or handbook for use by the public;

- are centrally located and publicly accessible to a substantial number of the recipient population; and

- agree to accept responsibility for filing amendments and changes forwarded to them by DHS.

Initial copies are issued to public custodians without a charge and when the handbook is reprinted in its entirety. All other requests have a charge related to the cost of reproduction.

Groups or individuals, other than those mentioned above, who request a handbook and agree to use it for informational purposes, may be furnished a copy at the discretion of the Commissioner or his/her designee. There may be a charge related to the cost of reproduction. Upon request, specific policy materials necessary for an applicant/recipient or his/her representative to determine whether a fair hearing should be requested or to prepare for a hearing may be made available to the applicant/recipient and/or representative without charge.

An up-to-date copy of the TennCare Medicaid Policy Manual is maintained in the county, district, and state DHS offices. Copies of portions of the manual will be made available upon request to students, researchers, and other agencies at cost of reproduction of the materials.

Right to Information or to File Informal Complaints

Persons or agencies who desire program information or wish to file an informal complaint about TennCare Medicaid may contact any or all of the following:
The Area Manager or FS I at the local county office. The phone number and address may be found in the telephone directory for the town designated as the county seat.

The District Administrator or District Family Assistance Director, whose name and address may be obtained from the Medicaid/TennCare Policy Unit located at 400 Deaderick Street, Nashville, Tennessee, 37248-7200.

Assistant Commissioner, Adult and Family Services
400 Deaderick Street
Nashville, Tennessee, 37248-0002

Commissioner
400 Deaderick Street
Nashville, Tennessee 37248-0001

APPEALS PROCESS

The Department of Human Services is responsible for all Family Assistance Appeals and Hearings, including both TennCare Medicaid and TennCare Standard eligibility. The TennCare Bureau continues to hear appeals regarding medical issues including services and service limits. DHS processes appeals based on eligibility work performed in our offices including Medical Eligibility (ME) denials, and premium and co-pay determinations. TennCare Standard and TennCare Medicaid enrollees have the right to appeal until 40 days (including mail time) from the date of the Termination Notice. Benefits will be continued if the appeal is received within 20 days (including mail time).

Right of Appeal

Every applicant/recipient must be informed of his/her right to appeal if he/she is aggrieved by an action or lack of action by DHS. Anyone who applies or wants to apply for TennCare Medicaid benefits must be given the informational pamphlet that explains the right of Appeal and Fair Hearing, the method by which a hearing may be obtained and that his/her case may be presented by a household member or a representative. All applicants/ recipients must be informed about these rights:

- verbally at the interview when he/she applies for benefits;
- in writing on the notice regarding the action taken on his/her application; and
- when he/she indicates disagreement with an agency action.

In addition, the appellant must be informed of any free legal representation that is available. DHS staff will refer the appellant to any legal services available in the community. All Department hearing records and decisions are available for public inspection and copying, subject to the disclosure safeguards provided by federal regulation. In addition, the names and addresses of appellants and other members of the public must be kept confidential.

Policy Statement

Any applicant for, or recipient of, TennCare Medicaid or TennCare Standard may file an appeal through the county office, District Office, State Office or the Family Assistance Service Center when dissatisfied with an action on his/her case. Complaints must be given prompt and careful attention and corrective action, when indicated, must be taken immediately. The county office or the Family Assistance Service Center must provide whatever assistance the complainant requires in appealing for a fair hearing. The county office staff must provide the appellant with a Tennessee Department of Human Services Appeal form or complete the form on his/her behalf.

If an individual files an appeal because he/she is dissatisfied with an action or lack of action by the county office, the county office will offer the complainant the opportunity to have a conference, with either the caseworker or the supervisor, to discuss the issue. The caseworker will inform the appellant that the conference is optional and will not delay or replace the fair hearing. The individual may also question the Department's interpretations of the law and the validity and applicability of the policies to his/her situation. Group hearings may be conducted where the sole issue is one of state or federal law, regulations or policy.

If the individual is not willing to discuss his/her grievance with local staff, he/she may request an appeal without a conference with the caseworker or supervisor. However, he/she should be encouraged to resolve the issue through the informal conference. If the individual files an appeal, it cannot be delayed or canceled without his/her consent because of the outcome of any subsequent informal conference.

Appeals

Appeals may arise from conflicts or dissatisfaction related to an action or lack of action by DHS such as, but not limited to:

- a decision regarding eligibility for TennCare Medicaid or TennCare Standard such as the eligibility begin date, individual excluded from assistance;
- termination of TennCare Medicaid or TennCare Standard benefits;
- failure to act on a request for TennCare Medicaid benefits within 45 days;
- state or federal laws, policies or regulations considered unfair or unreasonable;
- discriminatory treatment or practices on the basis of race, color, age, sex, handicap,
- religious creed, national origin or political belief (in the case of a discrimination complaint, see Rights and Responsibility chapter);

- amount of premium obligation for TennCare Standard or co-pay for TennCare Standard or TennCare Medicaid adults

- denial of Medical Eligibility for TennCare Standard

Division of Appeals and Hearings Functions
FAX all county office TennCare Medicaid and TennCare Standard appeals to the Division of Appeals and Hearings. The county office may continue to take action to resolve the issues in the appeal informally. If the informal hearings result in resolution, the county office must fax a Withdrawal of Appeal form to the Division of Appeals and Hearings. At that time, the appeal process will cease.

FAX all Family Assistance Appeals to:

Jo Murphy, Director of Intake and Conciliation
Tennessee Department of Human Services
Division of Appeals and Hearings
P.O. Box 198996
Nashville, TN 37219-8996
Fax: 1-866-355-6136 (Long Distance) or 313-5013 (Nashville or 615 Area Code)

The Family Assistance Service Center will accept appeal forms or file a verbal appeal on behalf of the TennCare Medicaid or TennCare Standard applicant or enrollee. The Family Assistance Service Center will document the request for an appeal on CLRC and enter the request for an appeal into the ARTS system. The responsibilities of the Division of Appeals and Hearings will be divided among the three units described below and organized according to the action needed on each case.

Intake Unit

The Intake Unit is the initial receiving point for appeals and miscellaneous mail. Intake Unit Staff will enter the appeals that have been faxed or mailed to them into the Appeals Resolution Tracking System (ARTS);

NOTE: When an appeal is entered into ARTS as complete, it automatically goes to the Conciliation Unit.

Conciliation Unit

The Conciliation Unit staff will be responsible for conciliation attempts concerning appeals. They will:

- determine if the appeal was filed timely;

- make an initial determination of whether it is fair hearable;

- determine benefit continuation/reinstatement pending the appeal decision;

- send a letter of acknowledgment of the appeal and information attachments to the TennCare Medicaid or TennCare Standard participant;
- resolve as many appeal issues as possible through communication with the appellant and the county office;
- ensure that the due process rights of the appellant are upheld;
- review the appeal to determine if the case action relative to the appeal was appropriate;
- make changes on items relative to the appeal;
- reinstate benefits if the case was closed because of caseworker error;
- contact the county office caseworker and FS1 to make the case correction if the Conciliation Unit is unable to do so;
- forward the appeal to the Case Preparation Unit if unable to resolve the issue.

Case Preparation Unit

The Case Preparation Unit will:

- prepare the case for a hearing with the Hearing Official;
- schedule the hearing and notify individuals needed to testify;
- write to the appellant and schedule the hearing; and
- give the appellant notice that will include the date, time, place and issue of the hearing.

After the hearing, the Hearing Official will issue an order. The Hearing Official will send the order to the appropriate county office that will take action to implement the order. The Case Preparation Unit will monitor implementation of the orders.

Timeliness for Filing Appeals

TennCare Medicaid and TennCare Standard appeals must be filed within 40 days (including mail time) from the mail date of the termination notice sent as a result of the case action. Benefits will be continued if an appeal is filed within 20 days (including mail time) of the notice or before the end date of coverage if that is later, pending the final decision of the Hearing Official. However, the individual must be informed that if the county's decision is upheld, the AG may be responsible for repaying the benefits paid

pending the decision. If benefits are to continue pending the outcome of the appeal, the Conciliation Unit will authorize the benefits on ACCENT or on Interchange as applicable.

When benefits are continued, the Hearing Official may determine at the hearing if the issue being appealed is one of law, regulation or policy or if the issue is a matter of fact or judgment. If the Hearing Official issues an oral decision that the issue being appealed is one of law, regulation or policy, the TennCare benefits must terminated immediately, as indicated in the original notice of adverse action. The Hearing Official will notify the appellant and the county office in writing that benefits must be terminated immediately pending the final hearing decision.

Once benefits have been continued, they cannot be terminated prior to the final hearing decision unless:

- the Hearing Official issues an oral and written decision that the issue being appealed is one of law, regulation or policy and that the appellant's claim that the county improperly computed the benefits, misinterpreted or misapplied such law or regulation is invalid;

- another change occurs while the hearing decision is pending that affects eligibility, and the appellant does not request a hearing on that issue during the ten-day adverse action period; or

- a mass change occurs while the hearing decision is pending.

Good Cause for Filing a Late Appeal

Appeals may be accepted after the 40-day time limit if the appellant can show good cause as to why the appeal could not be filed within 40 days. In addition, benefits can be continued if the appellant can show good cause for failing to file the appeal within 20 days. The decision regarding good cause is made by the Commissioner or his/her designee.

Filing an Appeal

An individual can file an appeal either orally or in writing. The appellant should give a clear statement about the issue of the grievance and his/her mailing address on the appeal form if the appeal is in writing. If the issue is unclear, the caseworker or the Family Assistance Service Center should clarify the issue prior to submitting the appeal. The caseworker or the Family Assistance Service Center must assist the appellant in filing the appeal in any way necessary.

The caseworker will explain on the appeal form the action taken or delay in action that is the issue of the appeal. This explanation should include:

- the date the appeal was requested (either orally or in writing);
- a clear statement of the action taken or delay in action taken on the case;
- the date(s) the action was taken on the case; and
- the state rule numbers of the policy in question.

The appeal form must be faxed to the Division of Appeals and Hearings on the date the appeal was filed. The caseworker will not wait for the appellant to sign the appeal form before submitting it to the Division of Appeals and Hearings if the appeal was filed orally or if the individual refuses to sign the form. If the appellant requests the appeal orally or refuses to complete the form, the caseworker will complete the form and fax it to the Division of Appeals and Hearings. Appeals that are requested verbally through the Service Centers must be entered directly into ARTS. Information must include:

- the case name and case number;
- the date the appeal was requested; and
- a clear explanation of the reason for the appeal.

If the individual first contacts the State Office to request an appeal, the State Office staff will get the pertinent information regarding the issue of the appeal and the appellant's name and address will be faxed immediately to the Division of Appeals and Hearings. The Division of Appeals and Hearings will treat this as any other oral request and process in the manner described above. All procedures described above will be followed for appeals initiated in the State Office.

The Responsibilities of the District Family Assistance Director

Copies of correspondence between the District Family Assistance Director, the county office, the Medical Evaluation Unit and others will be sent to the Division of Appeals and Hearings to inform them of the status of the appeal. Copies of correspondence coming from the appellant or others in the community about the facts of the case should also be sent to the Division of Appeals and Hearings. The responsibilities of the District Family Assistance Director may be delegated to the District Program Supervisor.

Interim Adjustments

While the appeal is pending, the county office or the Division of Appeals and Hearings will take any action on the case needed to correct an error or which results from changes in the AG's circumstances or in agency policies. Written notice of each change and advance notice, if required, must be given prior to the change.

In an appeal case where medical disability is the issue, the supervisor, the appellant or his/her representative and the caseworker must hold a conference to determine if more medical and/or social information can be obtained. If no new information can be obtained, the caseworker will then process the appeal form.

If more pertinent social and/or medical information is obtained, the appellant may request that his/her medical file be re-evaluated by the MEU prior to the hearing. The appellant must sign an original and three copies of the Consent for Delay form. The original copy should be held by the county office, one copy will be sent to the District Family Assistance Director, one copy will be sent to the Division of Appeals and Hearings, and one copy attached to the medical record that is sent to MEU. The case should include a letter explaining that the case is in appeal status. The MEU will then give prompt attention to the request for review and will respond with a decision.
If the MEU decides in favor of the appellant, the appellant will be asked to sign a Withdrawal of Appeal form. If the MEU does not decide in the appellant's favor, then the appeal process will continue.

In an Appeal case where medical incapacity is the issue, the supervisor, the appellant or his/her representative and the caseworker must hold a conference to determine if more medical and/or social information can be obtained. Any new information should be acted upon. The appellant may choose to continue or discontinue the appeals process regardless of whether or not new information is presented at the conference.

If more pertinent social and/or medical information is obtained, the appellant may request that his/her medical file be re-evaluated by the MEU prior to the hearing. The case should include a letter explaining that the case is in appeal status. The MEU will then give prompt attention to the request for review and will respond with a decision.

If the MEU decides in favor of the appellant, the appellant will be asked to sign a Withdrawal of Appeal form to withdraw the appeal. If the MEU does not decide in the appellant's favor, then the appeal process will continue.

Withdrawing an Appeal

If the appeal is resolved in favor of the appellant, the appellant will be informed of the same and will not have to withdraw the appeal in writing. If the appellant is satisfied with an adjustment or explanation of the reason for the action by local or district staff, or the Division of Appeals and Hearings Conciliation Unit, he/she will be given the opportunity to withdraw the appeal at any point during the appeal process.

The appellant should complete and sign a Withdrawal of Appeal form, giving the reasons for the withdrawal. This should be done in his/her own handwriting and words, if at all possible. If the appellant wishes to withdraw the appeal, but does not want to sign the form, the caseworker or Division of Appeals and Hearings worker will complete it and attach the appellant's written statement.

The caseworker or Division of Appeals and Hearings worker will complete the Withdrawal of Appeal form giving the reason for the withdrawal. The caseworker or Division of Appeals and Hearings worker must:

- explain any action being taken on the case;
- the dates of the action;
- the facts upon which the action was based;
- cite applicable laws or regulation; and
- any admissions, stipulation or agreements between the appellant and the agency.

If benefits are being restored, the effective dates of those benefits must be included, as well as copies of budgets if there were changes in income, need or AG composition.

Hearing Process

All hearings will be tape-recorded. Recordings will not be transcribed routinely. However, any party may request, at his expense or by the Division of Appeals and Hearings' expense, a transcript of all or any part of the recording. If the Division of Appeals and Hearings elects to transcribe the proceedings, any party will be provided a copy of the transcript upon payment of a reasonable fee. All recordings will be kept on file for no less than three years and then destroyed if there have been no further developments in regard to the appeal.

The Hearing Official will enter an Initial Order in writing, which will contain a report of the hearing and a preliminary decision regarding the hearing. The Initial Order will be sent to the appellant and the county office. The report of the hearing will include the following information:

- the names and identities of the persons present at the hearing;
- a statement of the issues;
- summary of the substance of the hearing that includes:
- a citation of oaths administered;
- a statement of the evidence presented;
- exhibits, stipulations, admissions, and matters officially noticed;
- questions and offer of proof, objections, and rulings on any objections; and

- attachments, which include the appeal form, the Withdrawal of Complaint (if applicable), the appeal summary prepared by the county office, acknowledgment notices, budget screens, and all documents or correspondence pertaining to the appeal.

The recommendation of the Hearing Official which will include:

- a concise statement of the issues;
- the facts brought out in the hearing;
- citation to the applicable law or regulation;
- the reasoning that led to the conclusion; and
- the recommendation to the Commissioner or his/her designated representative.

The recommendation is based exclusively on the evidence obtained in the hearing. Confidential or other information which the appellant or his representative does not have an opportunity to hear, see, respond to or consent to will not be introduced at the hearing nor become a part of the hearing record, since due process requires that all parties must have the opportunity of cross-examination and rebuttal.

The appellant and/or his/her representative, and the Case Prep Unit worker who attended the Hearing will receive a copy of the initial order. This will allow the parties to examine the order for completeness and accuracy. Any party to the hearing may file a Petition for Reconsideration and/or Appeal of the Initial Order by submitting written comments, arguments and exceptions to the order within fifteen days of the mailing of the report. In accordance with due process, it is not permissible to add new evidence that was not presented at the hearing.

The following information will be submitted to the Commissioner or his/her designated representative for the final decision:

- the report of the hearing;
- all exhibits and documents which were made part of the hearing record;
- a recording of the hearing or transcription, if one was made;
- Hearing Official's recommendation; and
- any additional comments, arguments and exceptions filed within fifteen days of the Hearing Official's decision.

The Final Order entered by the Commissioner or his/her designated representative shall either:

- adopt the decision of the Hearing Official as set forth in the Initial Order;
- modify and/or reverse the decision of the Hearing Official as set forth in the Initial Order, specifying the basis of the modification or reversal; or
- remand the case to the Hearing Official for a specified reason.

While the Final Order is binding upon all parties to the appeal, either party may file a Petition for Reconsideration of the Final Order within fifteen days of the date of the Final Order. This petition must be in writing, stating the specific grounds for the request. Filing a Petition for Reconsideration of the Final Order shall not supersede or delay the effective date of the Final Order. The Final Order will take effect on the date entered and will continue in effect until the Petition for Reconsideration of the Final Order is granted or until the Final Order is superseded, modified or set aside in a manner provided by law.

However, if a change affecting the recipient's benefits occurs while the reconsideration is pending, action to implement that change will not be delayed pending the decision on the petition.

Implementing the Decision

If the decision is in favor of the appellant and benefits had not been continued, the benefits will be reinstated and any lost benefits will be issued in accordance with the final decision. If the case was closed, an application is not necessary to reopen a case because of an appeal final decision.

If the final decision upholds the county's action and the Families First benefits have been continued, the AG's benefits will be reduced effective the first possible month after receipt of the decision. No advance notice is required to implement a hearing decision.

Time Limits for the Appeal Process

The maximum time limit for processing appeals is 40 days for the TennCare Medicaid and TennCare Standard Programs. The hearing can be delayed if the appellant is ill or if there is a delay in obtaining medical evidence because of circumstances beyond the control of the appellant or DHS.

Judicial Review

If the individual disagrees with the final decision in a fair hearing, he/she has the right to request a judicial review. The appellant must file a petition for review in the chancery court for the county in which the appellant lives or in the chancery court in Davidson County within 60 days of the date of the Final Order.

Documentation

A full explanation of the circumstances surrounding the appeal must be clearly explained in ARTS and in ACCENT CLRC running record comments. This should include:

- all of the issues in question;
- the reason for the county's decision;
- the outcome of any conferences regarding this matter;
- the outcome of the preliminary and final decisions of the hearing; and
- the action taken as a result of the final decision.

Procedures

Processing Fair Hearing Requests

When an individual requests a fair hearing, the county office will fax the appeal to the Director of Intake and Conciliation, Division of Appeals and Hearings.

All pertinent information regarding the appeal, such as what action was taken on the case that caused the individual to request the appeal, the program for which the appeal is being filed, and an explanation of the issue of the appeal, must be included on the form. The completed form must be faxed to the Division of Appeals and Hearings on the same day that the hearing request is received in the county office:

- original faxed to the Director of Intake and Conciliation, Division of Appeals and Hearings;
- one copy to the District Program Supervisor;
- one copy to the appellant and/or his/her representative;
- one copy to be retained by the county;
- one copy to the Commissioner's office, if discrimination is an issue; and
- one copy to the District Director of Investigation, if the action was based on an investigative report.

Routing of a Withdrawal of Complaint

The county office, or Service Center, will send the Withdrawal of Appeal form to the Director of Intake and Conciliation, Division of Appeals and Hearings, the day it is

received. The distribution for the Withdrawal of Appeal form is the same as for an appeal form, except that the original is sent to the Division of Appeals and Hearings, Director of Intake and Conciliation.

THE APPLICATION PROCESS

Policy Statement

Any person who wishes to apply for TennCare Medicaid has the right to do so. He/she will not be required to provide proof of eligibility before doing so. Proof of eligibility will be required before assistance is granted. TennCare Medicaid individuals will be required to provide proof of eligibility circumstances. In instances where the information is readily available to DHS or where it is more reasonable for DHS to secure the information, DHS will do so.

Availability of Program Information

Legal Base: 42 C.F.R. 435.905

Federal regulations require that the following information is made available in writing or orally to every applicant or other individual who requests it:

- TennCare Medicaid vendor payment eligibility criteria.
- Requirement of assignment of all third party medical support to the state.
- Requirement to make application for other income or benefits for which the individual might be eligible.

Provide the individual information that briefly describes covered TennCare services. More detailed information is available on the TennCare website at www.state.tn.us/tenncare/members/tcbenefits1.htm.

Refer specific questions regarding covered services to the Managed Care Organization (MCO) or Behavioral Health Organization (BHO).

Applicants need to:

- Provide complete and accurate information regarding their individual circumstances within specified time limits.
- Report changes in their individual circumstances within 10 days. Failure to report changes within this time limit may be interpreted as a willful attempt to commit fraud and any resultant overpayment of benefits is subject to recovery by the Bureau of TennCare.

NOTE: Provide the individual an HS-0746 (Change Report Form) at application, review, and whenever it is appropriate to do so.

TennCare Medicaid applicants/recipients have the right to appeal any action taken by the Department and to be represented by legal counsel. Information concerning appeals must be given with each application for assistance; AND

Have all information supplied to the Department kept in confidence and used only in the administration of the program; AND

Not to be discriminated against based on race, color, and national origin. Federal law also prohibits discrimination based on disability or language barrier.

Use of the Social Security Number

Legal Base: 42 C.F.R. 435.910; 42 C.F.R. 435.920

Explain to the applicant the following regarding the request for a Social Security Number (SSN):

- Applying for or furnishing a SSN is an eligibility requirement as of October 1, 1985. All individuals over the age of one must have a valid SSN to receive or continue to receive benefits.

- The SSN is used for identification purposes, to verify income and any third party payments. **NOTE:** Generally, application for SSN (enumeration) is completed on newborns before leaving the hospital; however, if the applicant does not have a Social Security Account Number DHS must assist the applicant in applying for a SSN.

- The individual's SSN is protected by the statute of confidentiality and is not released to individuals or agencies other than those involved in the administration of the TennCare Medicaid program. Only individuals living in the household that are actually applying for benefits are required to provide their SSN.

Program Provisions

The following must be reviewed with the applicant:

- The application processing time limits

- The interview requirement

- The eligibility determination process and verification requirement

- The collateral contact requirement
- The availability of retroactive TennCare Medicaid has been eliminated in all Medicaid categories effective June 1, 2007.
- The transfer of assets provisions (institutionalized individuals)
- The patient liability (institutionalized individuals)
- Estate Recovery (Institutionalized individuals)

Written Program Information

Provide the individual with the following pamphlets:

- EPSDT pamphlet
- Civil Rights
- Privacy Act
- Family Planning
- Fraud, the Law and You
- Appeals Information Form
- Additional pamphlets as appropriate

Application Procedures

The opportunity to apply for TennCare Medicaid is extended to every individual who wishes to do so. The following persons may file an application:

- The individual who requires assistance (the applicant) – a minor child must be at least 14 years of age.
- The applicant's responsible party - His/her responsible party (R/P) may represent the applicant who is unable to actively participate in the application process. The R/P may be a relative, friend, guardian, conservator, or any individual in a position to know of the applicant's circumstances.
- When there is a good reason why an applicant in a hospital or nursing home facility cannot sign an application, we may accept an application signed by the social worker, hospital or nursing facility administrator. The social worker or administrator must include a statement on the bottom of the application jus below the signature line indicating why the applicant was unable to sign the application, i.e. applicant is comatose, in emergency surgery, or physically unable to sign and there are no family members or other responsible party present to sign.
- The party acting in behalf of a minor child.

Filing the Application

In-person Application - If the individual or his/her responsible party applies in person, the date on which the applicant applies and signs the application is the application filing date. The individual may apply in person at the local county office of the Department of Human Services located in:

- The county where he/she resides; **OR**
- If confined to a LTCF, the county where the LTCF is located;
- A hospital where a hospital worker is located, which may or may not be in the county of residence. The specific procedures to follow regarding the processing of an application made at a hospital are detailed below in section *'Application Filed at Hospital'*.

Telephone Request - The individual may request an application by telephone and one will be mailed to him/her within 24 hours of the request. Applications are available online in English and Spanish at www.state.tn.us/humanserv/hs-0169. The application may be returned by mail, in person or by fax to the county office as specified below. The date the application is received in the county office is the application filing date.

Faxed Application - Applications may be faxed to DHS. An application received in any DHS office should be date stamped and forwarded to the correct office as needed. If otherwise eligible, TennCare Medicaid coverage may begin the date the faxed application is received by DHS (including holiday and weekends). Fax numbers for all DHS county offices can be found on the DHS web site: www.state.tn.us/humanserv, or by calling the Family Assistance Service Center.

County Responsibility - If the applicant moves before an eligibility determination is completed, after processing, The case is transferred to the new county of residence. Transfer only those pending applications that are recent and have little substantial information. Do not transfer a pending application when:

- The applicant has been interviewed; AND
- The verification needed to substantiate eligibility has been requested and/or the applicant has provided the same.

NOTE: The District FA Director will decide the transfer question in the event of a dispute between counties involved.

Application Filed at Hospital with an Outstationed DHS Caseworker

If the client applies for assistance at a hospital, the DHS caseworker should register the client and determine through statewide clearance whether he/she is active in the hospital county or another county. If it is determined that the client already has an active case, the worker responsible for the active case should be contacted to let him/her know that the client is applying for additional benefits at the hospital.

Client resides in county A and applies for TennCare Medicaid in county A. No active case on the data base:

- DHS hospital worker takes application; processes and authorizes all assistance groups.

- DHS hospital worker's supervisor transfers the electronic case record to the county office.

Active case in Hospital County

- Supervisor in county office transfers the electronic case records to DHS hospital worker. DHS hospital worker updates case in order to determine eligibility for TennCare Medicaid.

- DHS hospital worker authorizes TennCare Medicaid benefits; authorizes or re-authorizes all other assistance groups.

- Supervisor of DHS hospital worker then transfers the electronic case record back to county office maintenance caseworker.

*Client resides in County A and applies for benefits at hospital in County B. **No** active case in County A:*

- DHS hospital worker takes application and processes all assistance groups to authorization.

- The DHS hospital caseworker authorizes AGs and transfers the electronic case record to AG's county of residence.

NOTE: Verification information is the DHS hospital worker's responsibility. The DHS hospital worker needs to enter verifications which have been provided into the electronic case record.

- The DHS hospital caseworker authorizes the Food Stamp group as soon as possible.

*Client has **active** case in County A:*

- The DHS hospital worker requests the case to be transferred to him/her, enters verifications, and processes all assistance groups to authorization.

- Once TennCare Medicaid benefits are authorized, the DHS hospital worker can screen print from the electronic case record the information to advise the hospital of the eligibility status.

Written Application Requirement

Legal Base: 42 C.F.R. 435.907

A written application signed by the applicant or his/her responsible party is required. A faxed application meets this requirement.

When there is a good reason why an applicant in a hospital or nursing home facility cannot sign an application, we may accept an application signed by the social worker, hospital or nursing facility administrator. The social worker or administrator must include a statement on the bottom of the application jus below the signature line indicating why the applicant was unable to sign the application, i.e. applicant is comatose, in emergency surgery, or physically unable to sign and there are no family members or other responsible party present to sign.

Assistance with the Application

Legal Base: 42 C.F.R. 435.908

The applicant may be assisted in completing the application by any individual(s) of his/her choice. The DHS caseworker may assist the applicant in completing the application IF:

- The applicant requests assistance; **AND**
- The caseworker documents the request in the electronic case record.

NOTE: Review every item on the application with the applicant and request his/her initials to substantiate his/her agreement with the caseworker's entries.

Interview Requirement

Policy Statement

Interviewing plays a vital role in applicant, recipient, and agency communication. Interviews provide an opportunity for the applicant and recipient to communicate on a more substantive level. The skillful use of interviews permits the caseworker to obtain accurate, reliable information which is used to determine eligibility.

Most interviews for eligibility will be completed in an on-line, interactive mode. The interviews will be integrated so that information is collected to determine eligibility for all programs being applied for at the same time. The caseworker should strive to use the computer in a positive manner which helps gain efficiency and organizes information, but the caseworker must also use skill and judgment in knowing what to pursue outside of the questions on the ACCENT screens.

A face-to-face interview at application is required with either

- The applicant; **OR**
- The applicant's responsible party if the applicant is unable to participate in the application process.

NOTE: A telephone interview or home visit or other accommodations can be made if the applicant or his responsible party is unable to come to the county office for a face-to-face interview.

Purpose of an Interview

- The interview helps the A/R gain an understanding of the agency and its programs,
- Clarifies questions about eligibility and gives the A/R an opportunity to present her/his information in her/his own words.
- For the caseworker, the interview permits an opportunity to gather information needed to determine eligibility in an organized fashion.
- The interview provides the opportunity to discuss the rights and responsibilities of the A/R.
- The interview provides an opportunity to discuss other resources that may be of assistance to the A/R.

Mandatory Interviews

All TennCare Medicaid applicants will have a face-to-face interview prior to the initial authorization of eligibility and at 12 month intervals to redetermine eligibility unless the face-to face interview has been waived.

The interview will usually be with the applicant/ recipient. However, if the A/R has a guardian or authorized representative, this person may be interviewed in lieu of the A/R.

Scheduling Interviews

The county will schedule an interview as promptly as possible after the filing of the application in order to ensure that an eligible assistance group has an eligibility determination made by the 45th day after the application is filed (90 days for Disabled Adults).

An applicant who misses an interview is notified via the interview notice mailed from the data base client scheduling system that an appointment can be rescheduled if necessary. A second interview is not automatically scheduled. An application that is pending will be denied by the 45th (90th) day if the applicant does not reschedule a missed interview.

An active assistance group will have a reapplication review at 12 months or sooner if the residence group contains a Food Stamp group with earned income. The client scheduling module of data base provides an appointment notice to the AG the month before the AG reapplication is due. If the recipient fails to appear for the interview or contact the caseworker, the caseworker must send a 10-day Notice of Adverse Action closing the AG.

Single Interview

A single interview is conducted for all Family Assistance programs including TennCare Medicaid. If there are other assistance groups within the residence group, the caseworker must interview the head of each assistance group.

Waiver of the Office Interview

An office interview is required unless extenuating or hardship circumstances exist which prevent one.

Home visits are not required but may be used when no alternative accommodations can be made or no other accommodations are appropriate for the situation.

Information Provided to the Client during the Interview

The applicant/recipient is responsible for supplying verification to establish eligibility. However, the caseworker will obtain information that is available to the agency, or when it is more feasible for the agency to obtain the information. The individual should be given information as to what sources are acceptable. Never deny a case for failure to provide a particular source of verification when another source of verification is acceptable.

The caseworker will accept the applicant/recipient's statement as verification if:

- The individual tries but is unable to obtain the information; and
- The information is not available to and cannot be made available to DHS.
- Give the applicant/recipient an explanation about what information is needed and what proofs are acceptable.
- Inform the applicant/recipient that DHS will contact some individuals or organizations to establish proof of her/his eligibility. The applicant/recipient must

be given an opportunity to refuse to give the caseworker the right to secure information from the individual or agency.

- If it is determined that this particular person or organization is the only acceptable source for certain required information, and the applicant/recipient continues to refuse permission to contact, then deny or terminate eligibility.

- The Department will assist individuals who are hearing or visually impaired or otherwise in need of special assistance by providing a reasonable means of communication about the program and their case activity.

- Discrimination because of age, race, color, sex, handicap, religious creed, national origin or political belief is unlawful. The Civil Rights pamphlet must be provided to each applicant.

- Inform the applicant/recipient that information about her/his circumstances will be held in confidence.

- The applicant/recipient has the right to appeal any Department action that he/she believes to be discriminatory or unfair or when action on a request for assistance is not taken with reasonable promptness.

- It is unlawful for anyone to charge, either directly or indirectly, for help to the applicant/recipient in filing the application with the agency.

- A request for assistance must be completed within 45 (90) days. Approval can be made only after all eligibility requirements are met.

- Each assistance group member who is applying for TennCare Medicaid must furnish or apply for a Social Security number.

- Applicants/recipients are entitled to be referred to the Department of Children's Services, if requested. Individuals must be referred if evidence of child neglect or abuse is observed.

- Regarding child support, explain to all applicants/recipient with eligible dependent children in the assistance group that the caretaker must cooperate with Child Support Services to:

    - identify all absent parents;
    - locate an absent parent; and
    - establish court-ordered medical support;

- That the applicant/recipient can claim good cause for failure to cooperate and what that entails. (See Child Support Cooperation Chapter for details.)

- The individual can register to vote at the DHS office.

- If the applicant is approved, the AG will receive TennCare Medicaid benefits.

- If the A/R is eligible for other benefits (other than SSI), the A/R must apply for and

- Accept the benefits. SSI is a potential benefit when age or disability is a factor. Applying for SSI is optional, not required.

- Individuals under age 21 are eligible for Early Periodic Screening, Diagnosis and Treatment, EPSD&T, now called TENNderCare provided as a service of the Department of Health.

- At each application and review interview, give each applicant/recipient:

    - The Privacy Act pamphlet − The "You may get your child support while you are on TennCare Medicaid!" handout

    - The Civil Rights pamphlet

    - The information sheet on family planning.

Failure to Cooperate in the Eligibility Process

An adverse action to close a case for failure to cooperate will be initiated when the AG fails without good cause to provide requested information needed to establish eligibility for assistance. If the AG fails to comply with a **written** request for information or completion of specific action, send a 10-day adverse action notice. If the AG complies prior to the expiration with the 10-day notice requirement, assistance will be continued if eligibility is reestablished.

An application will be denied for failure without good cause to provide requested information prior to the 45-day (90) time limit. The case record must be documented to show that the information was requested **in writing** from the applicant and that the information was not available or could not be readily made available to the agency.

The TennCare Medicaid applicant/recipient has the primary responsibility for obtaining required verification; however, the caseworker must assist the individual when a good faith effort has been made and difficulties were encountered. The caseworker will rely on automated verification such as data exchange matches whenever possible. Obviously, if the information is readily available to the caseworker, the client should not be requested to obtain the verification. In any instances where the client is having difficulty obtaining the information, the caseworker must offer assistance in securing the verification. When it becomes known to the Department that an A/R has a disability which is causing difficulty in providing verification, the caseworker will assist the individual as indicated,

The assistance could include, for example, providing for the individual a reasonable means of communication, or soliciting the required verification document directly.

If the applicant notifies the caseworker that he/she is unable to provide the information within the 45-day (90) time limit, the caseworker should attempt to obtain the needed information. If neither the caseworker nor the TennCare Medicaid participant can obtain the information, the caseworker can accept the individual's statement as verification.

If an applicant is denied prior to the 45th (90) day for loss of contact and returns before the 45th (90) day and provides the required verifications, the original application date is protected and benefits will be provided retroactive to the application date or the eligibility date (if later than the application date).

Refusal to Cooperate in the Eligibility Process

Refusal to cooperate is **not** evident until the caseworker has explored the situation with the A/R in an attempt to help him establish eligibility, and to determine whether there is acceptable reason for any failure to provide needed information.

If it is determined that the AG is refusing to cooperate, the assistance case will be closed or denied. Once denied or terminated, the AG will not be determined eligible in subsequent application until there is cooperation with the Department. This policy applies to application and any subsequent review of eligibility, including regular redeterminations, reviews resulting from reported changes, and reviews by Quality Control staff.

VERIFICATION PROCEDURES

Policy Statement

Verification is the process of confirming or substantiating information provided by the applicant/recipient. Any decision made before the end of the standard of promptness period must be based on a clear determination of eligibility or ineligibility.

Verification is the responsibility of the applicant/recipient for TennCare Medicaid. The caseworker should secure verifications when the information is known to the Department through automated data interfaces, or when it is more reasonable for the Department to secure the information.

For a finding of ineligibility, the caseworker may render a decision based on the AG's unverified statement. For example, an AG reporting resources over the program's resource limit would be determined ineligible. However, to render a decision of eligibility, the worker must be able to make a firm determination of eligibility based on verified points of eligibility. Therefore, the verification process is central to the caseworker's ability to certify an AG for benefits. If there is any doubt of eligibility, the

caseworker must resolve it using the best evidence including documentary evidence, collateral contacts, and home visits.

The applicant/recipient's statement of the facts can be accepted as verification when:

- the AG has tried, without success, to obtain the needed verification and
- the caseworker has exhausted all means of securing documentary evidence, without success; and
- the documents needed are other than those required by another agency, as in unemployment benefits.

The record must be documented in narrative history on the data base the efforts that have been made and the results. The purpose of verification is to establish as accurately as possible that the AG meets defined eligibility criteria, and that the authorization of benefits is correct.

Documentary Evidence

Documentary evidence is written that is relied on as the basis, proof, or support of information provided by the AG and may be official or unofficial.

Official Documents

Official documents are those that are prescribed or recognized as authorized and are most commonly provided by business, agencies, and organizations engaged in specific enterprises or service delivery. A social security card, utility bill, or award letter is an example of official documents.

Unofficial Evidence

Unofficial documentary evidence may include such items as hand-written notes from employers, baby-sitters, etc.

Documentary evidence is considered the primary source of verification. When it is not available, collateral contacts, or home visits will be used. When using documentary evidence, record the title or type of document, document number, date of document, date seen, and contents.

Collateral Contact

A collateral contact is a verbal confirmation of the AG's circumstances by an individual outside of the home and who is knowledgeable of the facts being verified for the AG. The contact may be made in person or by telephone.

The caseworker may select the collateral or may ask the A/R to provide collateral. The caseworker does not have to accept the collateral named by the A/R. The caseworker should interview the collateral thoroughly enough to ascertain the relationship and reliability of the collateral so that a decision can be made that the collateral's statements are acceptable.

When using a collateral, the narrative history section of the data base must be documented stating the date of the contact, whether it was in person or by telephone, or in writing; document the name of the collateral contact; document the relationship of the collateral to the AG; and the content of the collateral contact.

Home Visits

A home visit may be scheduled to verify the AG's circumstances when there is no documentary evidence or collateral contacts.

The narrative history section of the data base should be documented with the date the home visit schedule and the date the visit was made and the information obtained during the visit.

Verification Required At Initial Application

- Residence in state
- Alien Status
- Age
- SSN or application for SSN
- Assistance group composition
- Relationship (for Families First Related TennCare Medicaid categories)
- Marital status (if applicable to eligibility or budgeting for eligibility)
- Living with a specified relative (for Families First Related TennCare Medicaid categories)
- Income, both earned and unearned, and from self-employment
- Resource
- How expenses are being met when expenses exceed income
- Dependent Care expense
- Loans
- Striker status when a strike is in the employment area and there is a history of employment
- Incapacity for purposes of deprivation (for Families First Related TennCare Medicaid categories)
- Pregnancy conception and expected delivery date if no other children in the AG (if applicable)
- Inconsistent information provided by the A/R or questionable information

Verification Required At Review/Redetermination

- Living with a specified relative (if applicable)
- Applied for a number and have not reported the number
- Residence
- Enumeration- verify Social Security Number of any members who have previously
- Gross income- earned, unearned, self-employed
- Deductible expenses

- Composition of AG
- Pregnancy (if applicable)
- Resources
- Striker status

Verification of Reported Changes

Recipients are required to report changes within 10 days of the date the change becomes known to the AG. Changes are subject to the same verification procedures and requirements that apply to initial applications or reapplications.

Verifications may be requested using forms contained in the Verification Subsystem of the data base in the default library on GroupWise or through electronic data exchange available through the data base and Clearinghouse.

Establishing the Applicant's Identity

Establish the applicant's identity through the verification of his/her Social Security account number and at least one other piece of identification such as a driver's license.

Determine if the individual has ever applied under another name or has an alias and include this information in the electronic case record.

Collateral Contacts

The applicant or the responsible party must provide the name, address and telephone number of at least 2 persons familiar with the applicant's circumstances and who, if possible, are unrelated to the applicant. At application and review, contact at least one of these persons to substantiate the applicant's allegations regarding their circumstances.

Include the following case documentation:

- Identity, relationship and phone number of the collateral,
- Length of time collateral has known the applicant and in what capacity,
- Specific items the collateral was able to confirm and those about which they had no information.

PROCESSING TIME LIMIT

Legal Base: 42 C.F.R. 435.911

Federal regulations specify the following maximum time limits for application processing. A notice should be mailed:

- For individuals applying on the basis of disability when disability has not otherwise been verified: 90 days from the application filing date.

- For all other applicants: 45 days from the application filing date.

The application may be held beyond the processing time limits if:

- There is an administrative decision beyond the caseworker's control; or
- The applicant delays or fails to take a required action in a timely manner; or
- The applicant has requested assistance in obtaining verifications; or
- An examining physician delays or fails to take a required action in a timely manner.

Document the reasons in the electronic case record for the delay in processing the application. Secure the client's permission to delay action on the application.

Adequate Notice

Once the eligibility decision is entered on the data base system, a computer generated notice of the eligibility determination is sent to the applicant and his/her responsible party the first work day following the day the aid group is authorized. The reason codes used on the authorization screen will generate the text for the approval or denial notice. The notice includes the following:

- The decision regarding the individual's eligibility.
- If eligibility is denied, the specific reasons for denial and citations of specific regulations that support the action.
- A statement to inform the aid group of its right to appeal hearing and the name and telephone number of the person to contact for additional information. If there is an individual or organization that provides free legal representation, the aid group will be advised of the availability of that service.
- A reminder to report changes within 10 days.

The caseworker is required to enter comments for all negative notices sent to the applicant/recipient, whether negative or positive action is taken.

Forms

The application interview is conducted with the client and responses online are reflected in ACCENT. However, certain forms are required as follows:

- Application for Assistance (HS-0169)

- Eligibility Determination Workbook (HS-2447) if the data base is unavailable during interview

- Change Report Form (HS-0746)

- Authorization for Source to Release Information (as found in Shared Base Documents in GroupWise entitled FA.DDS Medical Info. Release Authorization HS-2832)

Optional Forms Common to all Applicants

- Request for Financial Information (HS-0011)

- Voter Registration (if applicable)

- Other forms as appropriate to case situation (such as off-line worksheets, etc.)

APPLICATION FOR OTHER PROGRAM BENEFITS

Policy Statement

Legal Base: 42 C.F.R. 435.608

As a condition of eligibility, the applicant/recipient is required to take all necessary steps to obtain any benefits except public assistance to which he/she is entitled, unless he/she can show good cause for not doing so. Benefits mean financial benefits in the form of annuities, pensions, retirement and disability benefits including but not limited to:

- Veteran's compensation, pension and VA contract payments (but not VA A&A)
- OASDI benefits (Social Security)
- Railroad Retirement Benefits
- Unemployment compensation
- Worker's Compensation Benefits

Public Assistance is defined as:

- Supplemental Security Income (SSI)
- Families First/TANF (Temporary Aid for Needy Families), formerly known as Aid to Families with Dependent Children (AFDC)

Penalty for Failure to Apply:

Unless the individual can demonstrate good cause for his/her failure to apply for other benefits, he/she is not eligible for TennCare Medicaid benefits.

Caseworker Responsibilities

NOTE: Throughout the procedures sections of this Chapter, any reference to the client includes his/her responsible party or the individual applying on his/her behalf.

At application and redetermination review

The caseworker is required to notify the client with possible entitlement for other benefits:

- Of the requirement that he/she apply for benefits; AND
- The time limit for that application; AND
- Acceptable evidence of his application.

If, after expiration of the time limit, the client has not applied for benefits and cannot show good cause for his/her failure to do so, deny the application or terminate his/her TennCare Medicaid benefits for active cases.

If the client provides evidence of his/her application for other benefits, consider this eligibility condition satisfied.

Good Cause Provisions

The requirement that an individual apply for other benefits for which he/she might be eligible is waived if he/she has good cause for his/her failure to apply. An individual is considered to have "good cause" for his/her failure to apply for other benefits IF he/she does not have someone available to act on his/her behalf AND he/she cannot apply himself /herself for some reason, such as:

- The individual is not able to apply for benefits due to his/her own illness (explain that the SSA can have a telephone interview); OR
- The individual applied for benefits at one time, was denied, and he/she remains ineligible for the same reason.
- The individual is considered to have "good cause" for his/her failure to apply if the Department failed to advise him/her of the availability of other benefits.

Good Cause is not limited to the above examples. If the caseworker and supervisor agree that the individual has "good cause" for reasons other than those above, documents the electronic case record accordingly.

Applying the Good Cause Provision for Failing to Apply for Other Benefits

Once you have established the individual's "good cause" for his/her failure to apply for other benefits, take one of the following actions depending on case circumstances:

Hold the Application Pending

If the TennCare Medicaid application is held pending, give the applicant a specific deadline for filing an application for other benefits.

If the deadline exceeds the processing time limits and the TennCare Medicaid application becomes overdue, document the case record with an explanation of the reasons the application continues in a pending status. A program error does not accrue in this situation IF the case record is well documented.

If at the expiration of the deadline, the individual has failed to apply and does not have good cause for his/her failure, deny the application.

Approve the Application

If the individual is otherwise eligible, approve his/her application for benefits. Inform him/her that the requirement that he/she apply for other benefits has been temporarily waived, and he/she has an obligation to apply in the future. The time limit for that application and acceptable evidence of his/her application must be provided.

Set up an Expected Change to follow up on the individual's application and file evidence of his/her application in the case record.

Applying the Provision at Re-determination

If all other conditions and eligibility criteria are satisfied, count the re-determination complete and document the case record with a thorough explanation of the waiver of this requirement.

Set up an Expected Change to follow up on the individual's application if the requirement has been temporarily waived.

Possible Entitlement "Hints"

Black Lung Benefits

- An individual who is/was a coal miner and who is totally disabled due to pneumoconiosis; OR

- The dependent spouse, surviving or divorced spouse or the child (under age 18) of an eligible miner (or eligible at death), may be eligible for Black Lung Benefits.

Railroad Retirement Benefits (RRB)

- The individual, or his/her FRR worked for the railroad or a company closely connected to the railroad, and he/she is at least age 60 or disabled; OR IF
- The client is the dependent or surviving dependent of a railroad worker.

Social Security Benefits (SS)

An individual may be eligible for SS benefits if he/she or his FRR meets any of the following conditions:

- He/she is at least age 62
- He/she is disabled based on SS criteria
- He/she is a child under age 18 of a deceased, retired or disabled-worker
- He/she is the child who became disabled before age 22, of a deceased, retired or disabled worker

Supplemental Security Income (SSI)

An individual may be eligible for SSI if he/she satisfies the following criteria:

- At least age 65; OR
- Blindness or a disability that meets the SSI Criteria.
- Monthly Income limited to the amount of the current SSI FBR (plus $19) or less if living in the household of another.
- Resources limited to individual/couple level ($2000/$3000).

Veteran's Benefits (VA)

Veteran's benefits may be available under the following circumstances:

- If the client is a veteran of service in the U.S. Armed Forces and discharged under conditions other than dishonorable.
- If the client is the dependent or surviving spouse of a veteran.

Workmen's Compensation

These benefits are available to an individual who is:

- Injured or disabled on the job; OR
- The surviving dependent of a worker who is killed on the job.

PROHIBITION AGAINST CONCURRENT RECEIPT OF BENEFITS

Legal Base: 42 C.F.R. 435:403

Policy Statement

An individual is prohibited from receiving Medicaid benefits from 2 or more programs or from 2 or more Medicaid categories in the same state.

An individual is prohibited from receiving Medicaid benefits from another state concurrent with Tennessee eligibility unless the following exceptions apply:

- Admission to a long-term care facility, not a hospital or other short-term institution
- Confinement to a Tennessee LTCF for at least one full calendar month
- Satisfaction of all other eligibility requirements
- If the individual is a SSI recipient, the case file must contain a statement from the Social Security Administration that the SSI case will be closed or transferred.
- Documentation of Medicaid closure (or transfer of SSI) is received from the other state.

At-Home Individuals

An individual living at home is prohibited from receiving Medicaid from 2 or more programs within the state and from 2 or more Tennessee Medicaid categories simultaneously, except for those individuals who are eligible for QMB coverage and Medicaid. An individual living at home who is a recipient of Medicaid and/or SSI from another state is prohibited from receiving Tennessee Medicaid and QMB coverage

NOTE: Tennessee does not reimburse medical expenses using an individual's Medicaid card from another state. Tennessee Medicaid reimburses only on a Tennessee Medicaid Identification number.

Institutionalized Individuals

The earliest an individual who meets the above conditions and all other technical and financial requirements is the date of admission to a LTCF in the State of Tennessee. He/She is not eligible the month of admission.

NOTE: Expenses, such as, health insurance premiums incurred during the month of admission may be included as "Allowable Deductions" in determining patient liability.

An institutionalized individual is prohibited from receiving Medicaid benefits from 2 or more programs within the state and from 2 or more Tennessee Medicaid categories simultaneously except for those individuals who are eligible for Qualified Medicare Beneficiary (QMB) coverage and Medicaid. (Those individuals living at home who are recipients of Medicaid and/or SSI from another state are prohibited from receiving Tennessee Medicaid and QMB coverage.) An institutionalized individual who is a recipient of Medicaid and/or SSI from another state may be approved for Tennessee Medicaid as stated below

Recipients of Out-Of-State Medicaid

*Medicaid Eligible **NOT** confined to LTCF*

Deny or hold the application in pending status due to receipt of Medicaid in another state (exceptions are listed earlier) until documentation of Medicaid closure is received from the other state, then process the application as usual. The earliest day for Tennessee Medicaid eligibility will be the first day of the month after Medicaid ends in the other state.

Medicaid Eligible Confined to LTCF

The applicant confined to a LTCF is eligible the day of entry to a long-term care facility when he/she has been confined for at least 30 consecutive days or an HCBS individual who is determined to need and to be likely to receive services for a continuous period of at least 30 days going forward is eligible the day of enrollment in HCBS if all Tennessee Medicaid eligibility requirements have been met.

SSI Recipients NOT Confined to LTCF

Refer the recipient to the Social Security Administration to effect transfer of their SSI and Medicaid benefits to Tennessee.

SSI Recipients Confined to a LTCF

Inform the Medicaid applicant and his/her responsible party that the SSA must change the client's address to the new Tennessee address. The eligibility effective date will be the date of admission into the long-term-care-facility.

NOTE: Do not use the out-of-state Medicaid number on the manual institutionalized budget form (FORM 2362).

Paris – Public Assistance Reporting Information System

Tennessee participates in PARIS which is a voluntary information exchange system between states designed to identify individuals who may be receiving benefits or have unreported income in more than one state. Other states may request information to assist in resolving matches concerning individuals who appear to be receiving benefits in more than one state.

ASSIGNMENT OF THIRD PARTY MEDICAL SUPPORT

Legal Base: 42 C.F.R. 435.610; State Rule 1240-3-3-.02(8)

Policy Statement

As a condition of eligibility, the applicant/recipient is required to assign his/her rights to medical support or other third party payments to the State and to cooperate with the State in obtaining medical support and/or payments.

Definitions of Terms Used in This Part

- **Assignment of Rights** - When the client (or his/her responsible party) signs the Application for Medicaid Benefits, he/she agrees that his/her right to any medical support or payment for medical expenses is assigned or given to the State.

  The State reserves the right to receive reimbursement from any third party (including an insurance company) for any medical expenditure made by the TennCare program on the client's behalf.

  The client is required to return to the State any support or payments for medical expenses he/she may receive from a third party.

- **Medical Support** - Medical Support is financial support available to an individual for his/her medical expenses.

- **Third Party Payments** - Any payments made by an entity that is not the client and not the State including a responsible relative or an insurance company.

- **Cooperation with the State** - The individual is required to provide the State any and all information necessary to obtain medical support or payment including but not limited to the following:

    - Name(s) of party responsible for payment (e.g. responsible relative or insurance company)
    - Third party's address
    - Policy, account or claim number
    - Client's signature on all forms required for reimbursement

    The client is required to cooperate in any other way with the State in obtaining the medical support or payments to which he/she is entitled.

Medical Trust Fund

The individual is required to provide information regarding a medical trust fund established to defray or to entirely absorb his/her medical expenses including but not limited to the following:

- Location of the account
- Account trustee
- Account number
- Availability of the funds (e.g. limitations on disbursement)

Refusal to Cooperate In Assignment

The refusal to cooperate with the State in reporting and/or obtaining medical support or in the assignment of such support or third party payment to the State results in the applicant/recipient's ineligibility for program benefits.

Reporting Third Party Support

The Client's Responsibilities

The client is required to provide sufficient information to obtain the third party medical support to which he/she is entitled such as:

- The name(s) of the third party
- The address
- Any identifying information required to claim payment such as an ID number, claim or policy number

The client is required to cooperate with the State in any collection efforts including but not limited to his/her signature on all forms required to obtain reimbursement.

The client is required to report within 10-days the receipt of any cash reimbursement for medical expenses including the following:

- Insurance settlement and refunds
- Medical support paid by an absent parent
- Medical trust fund proceeds

Caseworker's Responsibilities

- Collect and accurately record in the case record all the information regarding the third party medical support.

- Report the third party support to the Bureau of TennCare Third Party Liability (TPL) Unit. This information may be faxed to TennCare TPL at 615-532-7509 if it includes information about Trust, Settlements or other information that cannot be entered on the system.

- Inform the client of his/her responsibility to comply with the requirement that he/she turn over any third party reimbursements he/she receive to the State.

- If the individual has had an accident, set up an Expected Change to follow-up on the receipt of any insurance settlements or judgments the client may receive.

How to Report Third Party Support

Support Other than a Trust Fund

Use BOTH of the following methods to report third party medical support to TennCare. TennCare will pursue collection.

- Complete appropriate computer screen (AEFMC) so that information will be transmitted electronically to the Bureau of TennCare. Document case record.

- Enter third party medical support, if other than health insurance company information, onto the data base. This data, along with other information, is transmitted overnight to TennCare.

  Third Party medical support is referred to as a "Medical Resource" (MRES) on the data base.

Reporting the Existence of a Medical Trust Fund

Report the client's access to a medical trust fund to TennCare TPL Unit in writing or by FAX. Include all the fund particulars as cited earlier.

TPL FAX number is 615-532-7509

TPL address is: TPL Division
310 Great Circle Rd., 4th Floor
Nashville, TN 37243

Key the trust fund as a medical resource on the data base.

Reporting Changes in Third Party Support

- Complete appropriate computer screen (AEFMC); OR
- Written correspondence regarding medical trust funds or case reimbursements; AND
- Make appropriate changes to the client information on the data base
- Types of Changes to Report:

    - Addition of third party support (e.g. purchase of health insurance or advent of Medicare eligibility)
    - Deletion of third party support (e.g. termination of health insurance coverage for any reason)
    - Third party change (e.g. coverage changed from insurance company X to company Z)
    - Receipt of cash reimbursement for medical expenses.

    When the need arises to contact the TPL Unit to end TPL coverage, the following information is needed:

    - Recipient's Name
    - Recipient's Social Security Number
    - Type of Coverage (inpatient, outpatient, pharmacy, dental, vision, etc.)
    - Policyholder's name
    - Policyholder's Social Security Number
    - Policyholder's Relationship to Recipient
    - Carrier Name and Address
    - Policy Number
    - Begin and end date of policy

    DHS may provide TennCare TPL Unit with a printout of ACCENT screen AEFMC. Most of the insurance information requested by TennCare exists on the AEFMC screen. DHS staff must add (legibly print) the full name and social security number of the individual(s) whose TPL coverage is ending and the end date of coverage as reported by the customer. The policyholder's name should be on the AEFMC screen and staff will add the policyholder's relationship to the individual(s) whose TPL coverage is ending (i.e. father, mother, spouse) and his/her social security number, if known. Once all information has been added to

the AEFMC screen printout, staff will then fax the printout to Ashley Ligon, TennCare TPL Division. The fax number is 615-532-7509.

COOPERATION WITH CHILD SUPPORT FOR MEDICAID APPLICANTS/RECIPIENTS

Policy Statement

Federal Regulation at 1912 [42 U.S.C. 1396k] requires as a condition of eligibility for Medicaid that:

- The individual assign the state any rights of the person who is eligible for medical assistance to any support for the purpose of medical care by a court or administrative order and to payment for medical care from any third party.
- The individual cooperate with the state in:
    - Establishing paternity
    - Obtaining support and payments as described above for the purpose of medical care.

  Unless the individual has good cause for refusing to cooperate as determined by the state agency.

  There is no requirement that the individual assign or cooperate with obtaining child support (cash, received for non-medical care) when the case is Medicaid only.

NOTE: Any child support arrears for a former Families First recipient are subject to collection until the total amount of Families First payments is repaid.

Sanctions

Sanctions will be applied when an AG refuses to cooperate with Child Support (IV-D) in obtaining medical support or establishing paternity.

If a caretaker, eligible adult or minor parent who is the caretaker of an AG refuses to cooperate with Child Support Services without good cause, the caretaker relative will be ineligible for benefits. The caretaker cannot be included in the AFDC-MO group but the children can be approved if all other requirements are met. Refusal includes failure to cooperate in establishing paternity or obtaining Medical support. Refusal to obtain cash support or to send direct cash support to Child Support cannot be sanctioned. The caretaker can also be sanctioned for non-cooperation with Child Support Enforcement (CSE). Non-cooperation with CSE is also limited to failure to assist in establishing paternity or obtaining Medical support.

The sanction for non-cooperation must not be applied until the child support worker has established that there are no extenuating circumstances that caused the non-cooperation such as illness, delay in mail, misunderstanding, etc., and the caseworker has established that good cause does not exist.

If a determination of failure to cooperate with Child Support Services is made, any children in the aid group may continue to be eligible.

Exemptions from Cooperation Requirements

The following are exempt from the cooperation requirement for Child Support:

- single parent adoptions;
- minor parent who is an eligible child in an AG who refuses to assign support;
- caretaker only" cases when the child in the AG is receiving SSI,
- an AG containing only a pregnant woman (child support cooperation will be required when the newborn child is added to the AG);
- absence is due to court-ordered public service in lieu of incarceration;
- caretakers who have been determined to have good cause for refusal to cooperate with Child Support Services.

Good Cause for Refusal to Assign Medical Support

There is no good cause reason for refusing to assign medical support.

Good Cause for Refusal/Failure to Cooperate with Child Support for Medical Support

Good cause can be granted for refusal/failure to cooperate with Child Support Services only under the following circumstances:

- It is reasonably certain that there will be physical or serious emotional harm to the child for whom medical support is being sought as a result of the caretaker's cooperation. If the good cause claim is made based on emotional harm, an emotional condition must already exist that cooperation would likely result in an emotional impairment that would substantially affect the child's functioning.
- It is reasonably certain that there will be physical or serious emotional harm to the caretaker that would reduce his/her capacity to provide adequate care for the child. If the good cause claim is made based on emotional harm, an emotional condition must already exist that cooperation would likely result in an emotional impairment that would substantially affect the caretaker's functioning.
- Pursuit of the medical support would be detrimental to the child because he/she was conceived as a result of incest or forcible rape.
- Adoption proceedings are pending for the child.

- The caretaker is being assisted by a public or licensed private social agency to decide whether to keep the child or relinquish for adoption. This good cause reason will be in effect for only three months.

Verification of Good Cause

All good cause claims must be verified. Verification is primarily the responsibility of the caretaker except when the information is already known to the Department or when it is more reasonable for the caseworker to obtain the needed information.

The following documents are acceptable for such verification:

- birth certificates, medical records, or law enforcement records that indicate that the child was conceived as the result of incest or forcible rape;

- court document or other records that show that adoption legal procedures are pending;

- court, medical, criminal, child protective services, social services, psychological or law enforcement records that show that the absent parent may inflict physical or emotional harm to the child or caretaker if cooperation is required;

- a written statement from a public or licensed private social agency that the caretaker is being assisted by that agency to decide whether to keep the child or relinquish for adoption; or

- notarized statements from individual other than the caretaker that have knowledge of the good cause circumstances. The statements should include what he/she knows about the situation and how he/she is in a position to know about the circumstances.

In some instances, the caretaker may claim good cause for physical harm, and there is no documentary evidence. For example, some battered individuals have not reported prior abuse because of fear or embarrassment. In these cases a determination must be made to determine the credibility and reliability of the caretaker. Good cause may be granted in these instances if the physical harm can be reasonably anticipated, and the case is fully documented to substantiate this decision. These decisions must be approved by the supervisor prior to granting good cause.

If the caretaker's statements and evidence are insufficient to make a decision about good cause, the caseworker may contact the absent parent if necessary. However, before contacting the absent parent, the caseworker must inform the caretaker so that he/she can provide additional verification, withdraw the application or have the case closed or withdraw the good cause claim.

Procedures

The appropriate ACCENT screens must be documented regarding the absent parent(s) for each AG child. In addition, documentation about exemptions, good cause determinations and procedures, and any other pertinent information about the medical support requirements must be documented in the case running record comments screen.

The medical support cooperation requirements, good cause process, and penalties must be explained to the applicant/recipient at the time of application and review.

If the individual is receiving child support, the amount of child support paid is counted as unearned income. The income will continue to be counted as long as the absent parent continues to pay the child support. This will ensure that the income is budgeted properly at application or if an income change is subsequently reported.

Upon Medicaid approval the information provided about the absent parents and good cause determination is transmitted to Child Support Services by ACCENT. Any changes to this information after approval will also be updated to Child Support Services. Closure of Medicaid cases also reported to Child Support Services through the systems interface.

IV-D Reports to Family Assistance

If Child Support (IV-D) reports any information about the absent parent or the AG to Family Assistance, the caseworker must take prompt action to review the information, determine its impact on the AG, and implement any necessary changes to the case. If IV-D reports that a named absent parent has been excluded by a blood test, the caseworker must contact the caretaker to inform her that:

- the man that she named has been excluded as the father of the child;
- it is no longer acceptable for her to name the same man as the absent parent;
- she must name the true natural father;
- she must explain why she named the previous man; and/or
- she must give a reasonable explanation of the true circumstances of the child's parentage.

If she does not do this, without good cause, sanctions must be applied. It is not acceptable for the mother to glibly name another man or merely state that she does not know the father's name.

Failure/Refusal to Cooperate With Child Support

If the caretaker, parent of an AG child or minor parent who is caretaker of his/her own case has failed/refused to cooperate with Child Support, **the child support worker must determine whether there has been willful non-cooperation or if there are extenuating circumstances that caused the problem.** These circumstances may include but are not limited to illness, delay in mail, misunderstanding, etc. If the child support worker reviews the circumstances and concludes that the caretaker had extenuating circumstances, the child support worker will work with the individual to remedy the reason for non-cooperation: schedule a new appointment, court date, etc. If the child support worker determines that the individual did not have a good reason for non-cooperation, the caseworker will be notified. Non-cooperation for a Medicaid only case does not include issues with cash (non-medical) support.

Good Cause Determination Procedures

If the caretaker, adult parent or minor parent who is caretaker of his/her own case claims good cause for non-cooperation, the caseworker must determine if the individual meets the good cause criteria for a waiver of the cooperation requirement **(see the criteria listed in the good cause section of this chapter).** If the individual's good cause claim meets our criteria, he/she must provide the required verification within 20 days after the claim is made. This time limit may be extended with supervisory approval in exceptional situations when the individual is having difficulty in obtaining the appropriate verification. A final decision on each good cause claim must be made within 45 days of the date the claim is made. This time standard may be extended only if the information required to verify or investigate the claim could not be obtained within the time limit or if the individual has been given additional time to obtain necessary verification. If the individual has complied with the requirements to establish good cause, benefits will not be denied, delayed or discontinued pending the determination of whether or not good cause exists.

A good cause claim will be denied if:

- the individual does not furnish the required verification within the 20-day time limit unless this time frame is extended;
- the evidence submitted does not substantiate the claim and the caretaker/parent does not submit additional evidence;
- the individual has not provided information for an agency investigation, if necessary; or
- the agency investigation establishes that the claim is not valid.

The results of a good cause investigation will be transmitted by ACCENT to Child Support (IV-D) when the pertinent information is entered on the appropriate absent parent screens. In addition, the caseworker must notify the individual in writing about the good cause decision.

If the good cause claim is denied, the caretaker must be given the opportunity to cooperate, withdraw the application or be advised that he/she will be removed from the case. If the individual continues to be non-cooperative, sanctions will be applied.

Once good cause is established, this decision must be reevaluated at review only if the circumstances on which it is based are subject to change. If the circumstances have changed, the individual must be given an opportunity to provide additional evidence to establish that good cause continues to exist. The same procedures used for the original good cause determination will be used to review the good cause decision. If the good cause determination is reversed, the caseworker will notify the individual that cooperation with IV-D is now required. The individual can claim good cause at any time if additional evidence becomes available and is presented to substantiate the claim.

CASE MAINTENANCE PROCEDURES

Legal Base: 42 C.F.R. 435.913

Case Documentation

Include all facts used to substantiate the eligibility decision (application or review) in the history section of the electronic case record and where otherwise indicated on the data base. Distinguish between fact and opinion in case recording.

Record all pertinent information and documents or online verifications used in the eligibility determination process (i.e. birth certificate, Medicare information, property deed, bank statement, medical bills, etc.), including date incurred/paid, type and provider, on specific screens in the data base and as appropriate in the electronic case record comments. Pertinent information and facts include but are not limited to:

- type and date of document used, information verified by document, form or documentation number, name and title of signatory on document (for example, employers statement of earnings period by Betty Brown, payroll clerk),

- date the documentation is viewed and by whom.

- In the event no documentation is available for income and resources, client statement can be accepted. NOTE: Do not keep originals of documents. Return these to the client.

The eligibility decision in the electronic case will be either an approval, denial, or closure UNLESS the individual withdraws his/her application. Record pertinent information regarding request for withdrawal in the history section of the data base. Deny on the data base with reason code 410 so the client receives a written notice that his application is considered withdrawn and requires no further action.

If a client cannot be located, record all efforts (including phone calls and written request for contact) to locate the individual in the history section of the data base, then authorize a denial due to "loss of contact". Include the following about all sources of information/verification:

- Identity of the source
- Relationship/connection to client
- Type of contact: written correspondence [WC], telephone contact including the number called [TC], personal contact [PC]
- Date(s) of contact/correspondence/pay stubs
- Nature of the information provided by the source

Always date-stamp mail with date received to assure chronological sequence in updating information in the electronic case record.

Re-Application Procedures

Accept a re-application when the individual submits a written request for one within 90 days of the date of his/her most recent:

- Denial (rejection) of an application for benefits, OR
- Closure of his/her active TennCare Medicaid case.

The client and/or the responsible party must submit a written re-application request (completed and signed HS-0169). The application may be faxed, mailed, or brought to the office. Review all eligibility criteria and secure current verification as required for a re-determination. Update the appropriate ACCENT screens with current information and document all verification on CLRC. The date of a previously signed application may be used as the application sign date for a re-application when:

- The previous application was denied prior to the 45th/90th day (for disability determination); AND
- Verification needed to determine eligibility is provided prior to the end of the 45th/90th day period.

An interview with the client and/or responsible party has first priority. If it is not possible to conduct a face-to-face interview, waive the face-to-face requirement and attempt to interview by telephone. An explanation should be recorded in the running comments in ACCENT.

Re-Determination (Review) Procedures

The initial eligibility re-determination is due 12 months following the month the application was approved. Review all technical and financial eligibility criteria. Document CLRC for all verifications used to establish eligibility.

A review becomes overdue when 12 months have passed without a redetermination. The 12 months begins with the month following the completion of each review. The review is considered timely if the review is completed by the last day in the month in which it is due. A review is completed every time a case is closed. However, because of the 10-day adverse action period, the review might be considered complete as many as two months prior to the effective date of closure.

If the recipient is visiting out of the state or county at the time of the review, a contact must be made with him/her through correspondence with the DHS office in the community in which he/she is visiting. If the recipient is too ill to be interviewed or is otherwise unable to participate in an interview, information regarding the situation must be obtained from the person who is responsible for the recipient's care or from the legally appointed guardian or conservator.

Changes Between Reviews

Some cases may need more frequent contacts than every 12 months because of changes in the aid group's circumstances that can be expected. Any changes expected by the aid group should be recorded in the data base on the appropriate screen.

When changes occur between reviews that affect the aid group's eligibility, the caseworker must adjust the case. The aid group must report all changes within 10 days of the date that the changes become known to the aid group. Changes may be reported by telephone, in person, or by mail using the Change Report Form, HS-1047. The ten-day period will begin with the date the change becomes known to the aid group. The change will be considered as reported on the date the report of change is received by the county. If mailed, this is the date the envelope is

date-stamped. Each Change Report Form will be date-stamped immediately when received in the county office. The date the change was reported must be recorded in the history section of the data base.

If the aid group failed to report a change and received benefits to which it was not entitled, the caseworker will complete the necessary steps to report an overpayment.

The county DHS Office will not impose any reporting requirements on the aid group. The caseworker will not treat the submission of changes as a waiver of the aid group's right to a 10-day adverse action notice unless the recipient indicates in writing that he/she understands that the report will reduce or terminate assistance. The caseworker will provide a Change Report Form and postage-paid envelope to the aid group at each approval, at review, and when a Change Report Form is returned by the aid group. A Change Report Form will be provided to the aid group more often if necessary. The caseworker will encourage the aid group to use the form when a change is being reported.

The caseworker will act on the changes reported by telephone and in person in the same manner as those reported on the Change Report Form. The caseworker must inform the aid group of its responsibility to report changes within 10 days at application and at each review. The caseworker will take prompt action on all changes to determine if the change affects the aid group's eligibility or benefit level.

The caseworker must record all changes on the appropriate data base screens and give a full explanation of the changes in the history section of the data base. The documentation should include:

- When the change was reported;
- How the change was reported;
- What was used to verify the change
- What action was taken on the change; and
- If the aid group filed an Appeal for Fair Hearing during the ten-day notice period and whether or not continued benefits were requested.

Negative Case Actions

Legal Base: 42 C.F.R. 435.912

Adequate notification of an action taken on a case is required by the regulations. Any action that has a negative effect on the client's continued benefits requires adequate and advance notification. Negative Action includes:

- Termination of benefits
- Reduction of benefits
- Increase in the amount of patient liability
- Reduction or discontinuation of TennCare Medicaid services (i.e., discontinuation of nursing care vendor due to transfer of assets penalty).

NOTE: Always determine if all the family members are eligible in any other TennCare Medicaid category prior to case closure/rejection in one category. Provide information on the Notice of Disposition regarding spend down liability and other conditions that impact the child under 21 or pregnant adult's eligibility. Proceed to TennCare Standard and process as a TennCare Medicaid Rollover for a child under age 19 if not eligible in another TennCare Medicaid category.

Adequate Notification

- A statement of the action to be taken (e.g. termination of eligibility for TennCare Medicaid benefits).

- The reason for the intended action (the client has moved out of state). Data base reason codes used on the authorization screen in the data base must be checked carefully and revised/updated as needed to ensure the appropriate information is conveyed regarding reason(s) for action.

- The effective date of the action taken on the case.

- The specific regulations that support the action or the change in Federal or State law that require the action.

- A statement regarding client's eligibility in other categories.

- The client's right to appeal the action through an Administrative Fair Hearing.

- An explanation of the circumstances under which TennCare Medicaid is continued if a hearing is required.

Advance Notification

Legal Base: 42 C.F.R. 435.919

If the aid group reports a change that will reduce or terminate the TennCare Medicaid benefits or remove a person from the aid group, then action cannot be taken until the 10-day adverse action notice has expired. The adverse action notice period will allow the aid group to provide any information/verification that will alter the decision to reduce or terminate the benefits or request an Appeal for a Fair Hearing and continue the benefits pending the outcome of the hearing. If the aid group presents evidence during the 10-day period that establishes that the aid group is still eligible, benefits will be reinstated without a new application.

The 10-day adverse action period count begins the day after the day that the Notice of Adverse Action is mailed to the aid group. If the tenth day falls on a weekend or holiday, the tenth day will end at the close of business on the next working day. The Notice of Adverse Action must be mailed to the aid group at least ten days prior to the effective date of the action. If the recipient requests an appeal of an adverse action within 10 days of the notice, he/she must be given the option of continuing benefits pending the outcome of the appeal. If the recipient opts to continue benefits, the caseworker must authorize the benefits at the pre-change level. The

caseworker must inform the recipient that if the county is upheld in the appeal decision, the benefits paid during the period between the hearing request and the decision are subject to recovery.

If the recipient reports a change in circumstances or presents additional evidence during the advance notice period that changes the decision on the case, the benefits should be continued at the appropriate level based on the new information. If the new information does not affect the decision, the reduction or termination of benefits should become effective as specified in the notice originally.

There are some exceptions to the requirement of at least 10 days notification before the effective date of the action. Advance notice is not required in the following situations:

- Factual information confirming the client's death.
- Clear written statement from the client waiving his/her right to advance notification.
- Written statement from the client indicating he/she no longer wishes services.
- The client's whereabouts are unknown and the post office returns mail directed to him/her indicating no forwarding address.
- Establish the fact that the client has been accepted for TennCare Medicaid services by another program or state.
- The client has been admitted or committed to an institution where he/she is not eligible to receive benefits.
- The client has entered a skilled nursing home or intermediate care facility and vendor payments will be authorized.
- A child is removed from the home as a result of a judicial determination or is voluntarily placed in foster care by his/her parents or legal guardian.
- DHS has received notification that an aid group member has been approved for SSI.
- Assistance is to be discontinued or reduced as the result of an appeal decision which upholds the county office.
- The aid group fails to show up for a review appointment.
- When closing a case, document CLRC regarding the circumstances causing case closure and the reason for the closure. See the Medicaid Extend Process section of this chapter for more information on closures.

Caseworker Alerts

Data Base Worker Alerts (also called Function 1 Alerts)

The database system generates alerts bases on conditions in a case (i.e., age change, disability/incapacity review due, SSA-SSN discrepancy, etc.). See tables on the database for a description of alerts produced. Action on Caseworker Alerts must be taken within 10 days of the receipt of the alert. Any negative action taken as a result must follow all the applicable information and notification requirements as noted previously.

Data Base Data Exchange Alerts (also called Function 6 alerts)

The database system generates alerts based on matches with many government agency computer systems, such as the Social Security Administration and the Department of Labor, for the purpose of determining whether a recipient has unreported income or resources that might be available to meet his/her living expenses. These alerts are received on the database and in a report on the INFOPAC system and are referred to as data exchange alerts. Another method of receiving and resolving these data exchange matches occurs when the database requires the resolution of the alert before action can be taken on a case. The database requires resolution of data exchange matches before:

- An assistance group can be authorized (approved, closed, or denied) on the authorization screen;
- A case can be transferred to closed files;
- A case can be transferred to another county; or
- A denied application that has not been taken through the database driver can be moved to closed files.

Transferring Cases

How to Transfer a Case

Application/Initiating County – county where the application originally was filed or where the currently active case is located.

New/Accepting County – the county accepting the transferred case/application.

The responsibility for the final decision regarding the transfer of an application belongs to the application county using the following guidelines:

- The county to which the applicant has reported his change of address will determine the status of the change (i.e., permanent or temporary) and if permanent, report the same to the application county.

- Transfer only those pending applications that are recent and have little substantial information. Do not transfer a pending application when:

    - The applicant has been interviewed; AND
    - The verification needed to substantiate eligibility has been requested and/or the applicant has provided the same.

    NOTE: The District FA Director will decide the transfer question in the event of a dispute between counties involved.

- The application county initiates the transfer within 24 hours of notification of the client's permanent relocation. Refer to the database Users Guide and database Procedures Guide for instructions on transferring a case.

- Notify the client that his active case is being transferred to his/her new county of residence

- Make appropriate changes to the data base

- Forward the case record to the accepting county

- Include documentation on the data base history screen, highlighting the following:

    - Pertinent identifying information
    - Expected changes NOTE: TennCare Medicaid cases are required to be l**eft open during transfer.**

CLOSURES FOR TENNCARE MEDICAID EX PARTE REVIEW, MEDICAID EXTEND, AND MEDICAID ROLLOVER

Policy Statement

Prior to an individual losing eligibility in any category of Medicaid, DHS is required to perform an ex parte review to determine if eligibility can be established in another open category of TennCare Medicaid. For children under age 19 losing Medicaid coverage, rollover to TennCare Standard must be processed and coverage opened, if they are otherwise eligible. See Medicaid Rollover section for details. When DHS does not find an individual eligible in a new category of Medicaid during the ex parte process and Medicaid coverage is closed on the DHS system, the Bureau of TennCare will select the individual for the Medicaid Extend process which is described below.

Ex Parte Process for Medically Needy Children and Pregnant Women

DHS receives a monthly file from TennCare which includes all MN children and pregnant women with an end date on the TennCare system 90 days in the future. Information for these individuals is available for viewing in the DHS Ex Parte Database. In addition, matching is processed with SSA to determine any potential link with SSI related categories. DHS must process an ex parte review for each individual using information available from SSA matching

and in the DHS case record. If there is sufficient information available, the individual may be opened for Medicaid in another category of Medicaid. Children under age 19 may be eligible to Rollover to TCS if current income and access to insurance information is available. When no eligibility is established, the Bureau of TennCare will select the individual for the Medicaid Extend process which is described below.

Ex Parte Process for all Other Medicaid Category Closures

Whenever Medicaid is closing, it is required that all individuals are processed for possible eligibility in other open categories of Medicaid. This is true for closures based on a reported change, as well as closures in time-limited categories such as Transitional Medicaid (TM), Newborn Medicaid, and Post Partum Medicaid for pregnant women. When processing a reported change, such as increase in family income, there has been contact with the client. In this situation, sufficient information is either available or can be requested to complete a determination for other open categories of Medicaid, or rollover to TCS for children under age 19. Cases in which there has been no contact or which have no associated open aid groups, such as Food Stamps may have insufficient current information (within the last 12 months) about income, family composition, access to insurance, etc. Contact with the client should be initiated and information obtained if possible.

If eligibility in another category of Medicaid or eligibility as a Rollover to TCS does not exist, the Bureau of TennCare will select the individual for the Medicaid Extend process which is described below.

Exceptions to the Ex-Parte Review

An ex-parte is not required when a Medicaid case or individual closes for one of the following reasons:

- Client reports moving out of state for all aid group members. The out of state address should be entered on the data base so it is transmitted to the Bureau of TennCare, if the address is known.

- Client is deceased. Date of death should be documented in the data base. Notify the TennCare Medicaid Policy Unit in the DHS state office with the deceased's name, SSN, and date of death, unless the date of death is already present on the TennCare system.

- Client is incarcerated. Information about the name of the correctional facility, length of sentence, and begin date of incarceration should be documented in the data base.

- Written voluntary request for closure for all aid group members. Again, document in the data base the date of the request, who the request is from, and whose case is requested to be closed. If there is a known reason for the request, document this as well.

Medicaid Extend Processing

Request for Information (RFI) Process for Medicaid Extend

- Mailing of RFI

  TennCare selects individuals monthly whose Medicaid eligibility is due to end by the end of the current month, or by the last day of the next calendar month for mailing of an RFI. At the point of selection, the end date for selected individuals is extended out to the last day of the next calendar month. TennCare mails:

  - Request for Information form (TN A047B.ext), which is green,
  - Cover page (TN A047a.ext), and
  - Medicaid Extend Letter (TN 039.18rfi)

  The individual is given instructions to complete the RFI with updated information and return them to DHS by a specific date, the last day of the next calendar month, in order for DHS to determine Medicaid eligibility in open categories of Medicaid or, for children under age 19, rollover to TCS. If the last day of the calendar month falls on a weekend or holiday, the date is moved to the next business day.

  Information is provided in the letter about getting help in completing the RFI pages due to a health, mental health, learning problem or disability, or help in another language and directs them to call the FASC for assistance. For those with mental health problems, it directs them to call the TennCare Partners Advocacy Line for assistance.

- Timely Receipt of RFI by Due Date on Medicaid Extend Letter

  When the RFI is received timely, by the date indicated on their Medicaid Extend letter from TennCare, and the individual is processed as a pending Medicaid individual, coverage will remain open on the TennCare Interchange system until a final decision is made regarding eligibility.

- Receipt of RFI by End Date of Coverage

  When the RFI is received after the due date indicated on the Medicaid Extend Letter, a no response termination notice will be processed by the Bureau of TennCare. However, if the RFI is received prior to the end date of coverage, it may still be processed and coverage will remain open until DHS completes the determination.

- Receipt of RFI after the End Date of Coverage

  DHS will process Medicaid Extend RFI forms received after the end date of coverage as Medicaid applications. While an individual may become Medicaid eligible again, there will be a gap in coverage dates.

- Processing of the RFI by DHS

  Upon receipt of the TN A047B.ext green RFI form prior to the end date of coverage, the caseworker will:

- Determine if the form is signed as required
- Determine eligibility for all potential categories of Medicaid. This may require additional information such as resources or incapacity information for example, in some situations.
- Determine if all needed verifications have been provided

If verification is needed, a verification request form must be sent indicating what specifically is needed and the 10th day by which it must be returned.

NOTE: If the only group a child under 21 or a pregnant woman is potentially eligible for is spenddown, and all eligibility requirements are met except for providing sufficient incurred medical expenses, the application must be denied. The client will have 90 days from the RFI receipt date (application date) to present incurred medical bills that meet the criteria for countable spenddown expenses, in order for the original application date to be reinstated and Medicaid eligibility approved.

Medicaid Rollover Processing as Part of Medicaid Extend

MN children who have reached the end of their 12 months of eligibility on the TennCare system and who were not determined Medicaid eligible during the ex parte review will receive the Medicaid Extend RFI. In order for such a child to be processed as a Medicaid rollover the Medicaid Extend RFI must be received prior to the end date of coverage. If the forms are received after the end date of coverage, Medicaid rollover is not allowed.

Medicaid Extend Processing by the Bureau of TennCare

The Bureau of TennCare will do the following processing for Medicaid Extend cases after the mailing of the RFI:

- Send a termination notice giving 20 days advance notice of closure with appeal rights when the RFI is not received by the due date listed on the Medicaid Extend letter.

- Send termination notice giving 20 days advance notice of closure with appeal rights to individuals denied Medicaid by DHS.

- Send TCS denial notice with appeal rights to any child processed by DHS when the child is not eligible for TCS as a Medicaid rollover. This notice would be in addition to the Medicaid termination notice based on DHS Medicaid denial listed above.

No termination notice is produced by TennCare prior to the due date listed on the Medicaid Extend notice. Even if DHS has processed a Medicaid denial earlier in a month, the 20 day advance notice of termination produced from TennCare will not be created until after the due date.

Processing Medicaid Rollover Cases for Children Under Age 19 Losing Medicaid

Medicaid Closures Based on Reported Changes

When a reported change results in closing of Medicaid coverage for a child under age 19, processing for TennCare Standard as a Medicaid Rollover is required even if the child is not eligible technically. If a child losing Medicaid has access to insurance for example, a transaction to deny the child for TCS with the correct denial reason code ensures that a notice is created from TennCare which informs the family of the reason for denial and gives appeal rights.

EXCEPTIONS:

- Do not process a child for Medicaid Rollover if the client requested Medicaid closure in writing.
- Do not process a child for Medicaid Rollover if the Medicaid closure is due to death
- Do not process a child for Medicaid Rollover is the Medicaid closure is due to the child becoming eligible for SSI Medicaid.

An application is not required to process a Medicaid Rollover based on a reported change, but all required verifications must be provided in order to open a child for TCS as a Medicaid Rollover. This may include income verification, and access to insurance verification.

Whenever possible, the authorization to approval or deny TCS should be done the same day as the closure for Medicaid. If this is not possible due to outstanding verifications, and the child is later approved, be sure that the application date used for the TCS approval is a date prior to the Medicaid end date on the TennCare system.

In situations when an ME packet must be requested due to family income at or above 200% FPL, there may be a longer period of time between the Medicaid closure transaction and the final ME transaction if the child is approved for TCS coverage as ME. Again, check to be sure the TCS application date is prior to the end date of Medicaid coverage in order to prevent any gap in coverage.

Medicaid Closures Based on Changes During the Annual Review

If a child under age 19 loses Medicaid eligibility due to changes reported during the annual review, sufficient information must be obtained at that time to process the child for TCS as a Medicaid Rollover. As above, even if information indicates that the child does not qualify for TCS, for example, due to access to insurance, a TCS transaction to deny the child for TCS is required using the appropriate denial reason code to ensure that a notice is created from TennCare which informs the family of the reason for denial and gives appeal rights.

An application is not required when processing for TCS based on closures during review.

EXCEPTION: When the Medicaid case is closed due to failing to complete the review or failing to provide required verifications. A new application must be filed prior

to the end date of Medicaid in order for TCS eligibility as a Medicaid Rollover to be determined. Applications received after the end date of Medicaid cannot be used to determine Rollover eligibility, but will be treated as Medicaid applications.

Whenever possible, the authorization to approval or deny TCS should be done the same day as the closure for Medicaid. If this is not possible due to outstanding verifications, and the child is later approved, be sure that the application date used for the TCS approval is a date prior to the Medicaid end date on the TennCare system.

In situations when an ME packet must be requested due to family income at or above 200% FPL, there may be a longer period of time between the Medicaid closure transaction and the final ME transaction if the child is approved for TCS coverage as ME. Again, check to be sure the TCS application date is prior to the end date of Medicaid coverage in order to prevent any gap in coverage.

Timetable of Monthly Events for Medicaid Extend Process

Medicaid Extend Selection happens Month End Weekend, called Recon weekend and is the weekend of ACCENT cutoff. This is normally the third weekend of the month. Those selected for Medicaid Extend processing will be individuals with an end date on the TennCare system within set date parameters, and who were not included in the prior month's selection. At the point they are selected, the end date changes, even though letters are not mailed for several more days. Those selected will be for an entire calendar month.

Mailing of Green RFI forms will happen the week after Recon weekend. This will occur normally by the Friday after Recon weekend.

Extension of existing end dates on the TennCare system, Interchange, happens when Green RFI forms are mailed. The date will be extended to the last day of the next calendar month or the next business day that falls on a weekend or holiday. This is the day by which they must return the RFI to DHS.

Notice of termination for no response to the Green RFI forms occurs if no form has been filed by the last day of the calendar month (date indicated on their notice). TennCare sends a 20-day advance notice of termination.

Response is received timely: DHS "pends" the case on the data base. This pending transaction causes TennCare to eventually lift the end date and replace it with no end date to coverage, until the DHS decision is completed. (The end date will probably by 12-31-2299.) The lifting of the end date on a pending case does not take place until the day before the coverage is set to end. For example, in the first cycle of processing, coverage extended to 8-1-05, since the last day of the month was on a weekend. If a case was "pended" on the data base and was still pending on July 29, the end date changed to 12-31-2299.

Termination when no Medicaid or TCS coverage results. The termination notice indicates that coverage ends on the 20th day fro the notice date. The no response termination letters will all be created at the same time. Termination notices for cases who DO respond timely but are no

longer Medicaid eligible and have the determination made prior to the day the no-response letters are created, will be sent at this same time. Termination letters are created daily.

FAMILY ASSISTANCE SERVICE CENTERS

The Department of Human Services offers an additional customer service option to clients through the Service Centers. The Services Centers work in partnership with the DHS county offices to answer program and case specific inquires, make case changes, reschedule appointments, and file appeals. Service Centers are open 7:00 am to 6:00 pm Monday through Friday and observe the regular state calendar regarding holiday closings. Telephone calls are accepted 7:00 am to 5:30 pm regardless of the time zone in which the call originates.

The following are the Service Center Telephone Numbers:

- Official Published Long Distance Telephone Number (866) 311-4287
- Official Published Local Telephone Number (615) 743-2000
- Official Published Long Distance Spanish Telephone Number (866) 311-4290
- Official Published Local Spanish Telephone Number (615) 743-2001

In partnership with the county offices, the Service Center answers program and case specific inquiries, makes case changes, reschedules appointments and files appeals. The Service Center staff has update capability into the case file. It is extremely important that all case input resources provide timely documentation in the case file. Service Center Workers have access to every TennCare Medicaid and TennCare Standard case in the state. In the event that they encounter a case that is in a "Confidential Caseload", they will be prohibited from corresponding with any County Office employee that is not directly responsible for the "Confidential Caseload." In addition, Service Center staff are required to sign a disclosure statement identifying any personal relationships with Family Assistance clients that may present a problem with administration of their benefits.

General Inquiries Regarding Family Assistance Programs

The Service Center accepts general inquiries. These calls may include Family Assistance programs and general eligibility inquiries, verification of Tennessee benefits for out-of-state agencies, and application inquiries. The Service Center staff responds to general program eligibility inquiries. They provide program benefit information and basic eligibility requirement information for TennCare Medicaid, TennCare Standard and Refugee Medical Assistance programs. The Service Center staff advises callers on how to apply for benefits. They mail applications to callers upon request. Mailed applications may include the initial application for program benefits that will be submitted to the County Office or an updated application due to a case change that will be mailed back to the Service Center. The staff also informs clients of the location of the appropriate County Office where they may take their applications. Finally, staff provides clients information on application processing periods and prorated benefits. If the caller has a question that is appropriate for another agency, the Service Center staff transfers the caller to the appropriate number/location. This includes inquiries such as, but not limited to:

- Child abuse/neglect;

- Adult Protective Services;
- Child Care: Fiscal Services, Complaints, and Resource and referral services;
- Customer Service Review (responding to contact letter or post card that was sent to client);
- EBT Hotline;
- USDA for Food Stamp program abuse;
- Investigations (Food Stamp and Families First potential fraud, pending
- Intentional Program Violation, including ADW appointments, overpayments, repayment agreements, dunning notices, IRS refund or lottery attachments to repay overages);
- Legal Aid;
- Child Support Help Line;
- TennCare Medical Services (for TennCare questions related to services, rather than program eligibility);
- Medical Eligibility (ME) Outreach information;
- Pre-Admission Evaluation (PAE) information; and
- Qualified Medicare Beneficiary (QMB)/Special Low Income Medicare Beneficiary (SLMB) Hotline.

The County Offices answers general questions addressed to them by clients, but may offer the Service Center as an option. If a client indicates that he/she prefers to address questions to the County Office or the County Office Case Worker, he/she should not be transferred to the Service Center and the County Office should provide the customer service.

General Inquires Regarding Family Assistance Case Status

The Service Center is required to follow protocol regarding case access. The staff requests the case number or member Social Security number for inquiry purposes. They then access the case and provide requested information. All calls are documented on the database Screen for "Service Center Inquiry" or the appropriate screens. Calls that are informational only and do not require follow up action, do not require the history section of the data base update.

If the call results in information sent to the caller, the Service Center documents the call and action taken in the history section in the database. The user tags all entries with their full name and User Identification Number (User ID) at the beginning and end of the free form text on the history section of the data base. Staff should include in the text the date of call, caller name,

information or document that was requested by the caller, date that the document was mailed/faxed, and method of transmittal (mail, fax, etc.).

When a staff member in the Service Center receives a case inquiry from an out-of-state agency to verify client benefits, he/she needs to ensure proper documentation for confidentiality purposes. The agency will need to fax a request on their department letterhead. The request must include client name(s), social security number, date of birth, programs being applied for, date of application, and current address and phone number of the client. Once the request has been received and determined appropriate, the staff member will search the data base to determine if the client is currently active for benefits. This includes any benefits, not just those about which the other state may be inquiring. If the client(s) does not have an active case for the program benefits requested in the other state, the form will be completed and faxed it to the State Agency verifying no current assistance. If the client(s) receives benefits currently for the requested programs, refer to the section on processing changes to proceed. If the client(s) receives benefits other than those about which the out-of-state agency is inquiring, action must be taken due to the possibility that the client is no longer a Tennessee resident.

At the point that the case action is completed and assistance terminated, the Service Center will complete the form and advise the other State Agency of action. If unable to complete action within a maximum of three days, the Service Center Worker advises the other State Agency that the client is currently receiving benefits, which are being re-evaluated for eligibility.

The County Office answers case specific questions addressed to them by clients, but the individual answering the main County Office telephone line may offer the Service Center as an option. If the client indicates that he/she prefers to address questions to the County Office or the County Office Case Worker, he/she should not be transferred to the Service Center and the County Office should provide the customer service.

Case Changes

The Service Center processes case changes for TennCare Medicaid and TennCare Standard. They take action on changes initiated by the Service Center through case authorization, issuance, and the resolution of match reports specific to that change. Within a client's case, the individual who initiates the change is the individual who becomes the "owner" of that action. All changes should be documented on the history screen on the data base by tagging the free form text at the beginning and ending of the entry with the "action owner's" full name and User Identification Number (User ID).

The Caseworker can always identify the location of the Service Center Worker who has an active work order by the alphabetical codes used in the Service Center Worker's User ID. User IDs for Service Center locations are as follows:

- DEKA - Morristown
- DEKB – Clarksville
- DEKC – McKenzie
- Memphis

In addition, each time the case file is accessed, the Case Worker should check the appropriate data base screen to see if there is an open work order, and then check the history section on the data base to see if an entry has been made by the Service Center. The County Office should also use the history section of the data base each day to document any actions taken by the Case Worker that will be of importance to the Service Center Staff. For each history screen entry, the Case Worker's full name and system User ID should be provided at the beginning and ending of each entry.

If a client provides case change information to the County Office that has not been directed to the Service Center or requested by the Service Center (by telephone, fax, mail or office visit) the County Office Case Worker should make the change and proceed with completing the change through authorization, notice issuance and resolution of matches.

However, if the County Office Case Worker checks the appropriate screen and notes that information received from the client is needed by the Service Center based on work order information and narrative history screen entry, he/she may fax the verification to the appropriate Service Center and expect the Service Center Worker to complete the change through authorization, issuance and resolution of any associated matches.

Rescheduling Appointments

The Service Center will reschedule appointments for Family Assistance clients.

Appeal Requests

The Service Center will notify the County Office Case Worker by e-mail along and copy the appropriate FS1, when an appeal is filed. The notification will be for informational only. Subject line will read: Appeal Filed: case name and case/cat/seq. Both the Service Center and the County Office will accept requests for appeals.

Voter Registration

The Service Center will verify when Voter Registration should occur. When a client calls the Service Center to request an address change or to inquire about voter registration, Service Center staff will mail an Application to Register to Vote to the client.

Reporting Potential Overpayments

If the Service Center identifies a potential overpayment, they will annotate CLRC and send an e-mail to the County Office Case Worker with a copy to the FS1. It will be the responsibility of the County Office staff to pend the claim in the Claims On-line Tracking System (COTS).

Changes That Require Referrals To Outside Agencies

If a change requires a referral to an outside agency in order to process, the Service Center Worker will annotate the AESCI screen regarding to whom the call was referred and the reason for the referral.

Case Changes Not Appropriate for Service Center

Generally, the Service Center will not be making changes on cases with pending applications, initial application processing, changes in month of recertification, cases overdue for review or recertification, nursing home cases and Refugee Assistance cases. However, if the client reports an address change during the application process or during the month of a review or recertification, the Service Center may update the case record and, if applicable, transfer the case to the appropriate County of residence. In addition, if a client has made an appointment for an initial interview and would like to reschedule that appointment, the Service Center may follow the Appointment Rescheduling process to reschedule the initial application appointment Documentation and Verification

EARLY AND PERIODIC SCREEING, DIAGNOSIS AND TREATMENT (EPSDT)

TENNderCARE

Policy Statement

TennderCARE is Tennessee's EPSDT program. The EPSDT program was designed for the care of a child from birth to young adulthood. Tennessee has made a commitment to promoting good health in children from birth to age 21. TENNderCARE is a full program of check-ups and health care services for children who have TennCare. The purpose of TENNderCARE is to assure the availability and accessibility of required health care resources and to help TennCare eligible children under the age of 21 and their parents or guardians effectively use these resources.

For more information about TENNderCare you can go to the TennCare website http://www.state.tn.us/tenncare/tenndercare/index.html

DHS Responsibility

DHS is responsible for informing applicants and recipients about the TENNderCare program. Brochures are available in English and Spanish and must be provided to each family with children under age 21. Posters about TENNderCare should also be prominently displayed in the DHS office waiting room. The eligibility counselor must also explain the importance of health checks and immunizations and encourage families to follow up with recommended services.

Eligibility for TenderCare Services

Every child (under 21) who is eligible for TennCare is eligible for TENNderCARE services. A child can be eligible for TennCare through Medicaid TennCare or TennCare Standard to age 19. TENNderCARE screenings are well-child check-ups. Children and adolescents should receive regular screenings even if there is no apparent health problem.

TenderCare Services

Screenings

Screenings are the initial step in identifying children with needs requiring more in-depth testing and diagnostic procedures. Screenings are provided to initially identify problems in a general area requiring further assessment/evaluation (such as behavioral or developmental) while diagnostic procedures should identify or rule out specific problems (such as ADHD or mental retardation). Screening instruments are also designed for use with all children during a well-child visit.

TennCare requires that TENNderCARE screenings be performed according to the standards of the American Academy of Pediatrics including:

- Comprehensive health (physical and mental) and Developmental History
- Comprehensive unclothed physical exam
- Health education/anticipatory guidance
- Vision screening
- Hearing screening
- Laboratory test
- Immunizations

Dental Services

At a minimum dental services must include relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services may not be limited to emergency services. Although an oral screening may be part of the physical examination, it does not substitute for examination through direct referral to a dentist. A direct dental referral is required for every child beginning at the age 3, or earlier if determined to be medically necessary.

Diagnosis

When a screening examination indicates the need for further evaluation of an individual's health, diagnostic services should be provided. The referral should be made without delay and followed-up to confirm that the enrollee receives a complete diagnostic evaluation. TennCare MCO's and BHO's provide diagnostic evaluations.

Treatment

Health care must be made available for treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services. Both the MCO and the BHO provide treatment.

Providers who perform TENNderCARE screens may identify potential health, behavioral, or developmental problems. They are responsible for making referrals to other MCO or BHO providers for further testing or treatment. While there is no requirement that periodic or interperiodic screenings meet the definition of "medically necessary", additional testing and treatment services must be medically necessary. Screening follow-ups are just as important as the initial screenings.

Lead Toxicity Screening

All children are considered at risk and must be screened for lead poisoning. TennCare requires the use of the blood lead test when screening children for lead poisoning. Physicians should use each office visit as an opportunity for anticipatory guidance and risk assessment for lead poisoning. All children from 6 to 72 months of age are considered at risk and must be screened. Any additional diagnostic and treatment services determined to be medically necessary must also be provided to a child diagnosed with an elevated blood lead level.

Interperiodic Screens

In addition to covering scheduled periodic check-ups, TENNderCARE covers visits to a health care provider when needed outside of the periodicity schedule to determine whether a child has a condition that needs further care. These types of screens are called "interperiodic screens". Persons outside the health care system such as a teacher or parent can determine the need for an interperiodic screen. Screenings shall be performed at distinct intervals and in accordance with the American Academy of Pediatrics Recommendations for Pediatric Health Care.

Outreach and Informing Activities

Outreach and informing activities are a requirement under TENNderCARE regulations. All MCO's should provide eligible individuals and/or their families basic information on what services are available under the TENNderCARE (EPSDT) program, the benefits of preventive health care, where the services are available, how to obtain them, and that transportation and scheduling assistance are available.

Periodicity Schedule for Check-Ups and Screenings

Infancy	Early Childhood	Middle Childhood	Adolescence
At birth	15 months old	5 years old	11 years old
2-4 days	18 months old	6 years old	12 years old
1 month old	24 months old	8 years old	13 years old
2 months old	3 years old	10 years old	14 years old
4 months old	4 years old		15 years old
6 months old			16 years old
9 months old			17 years old
12 months old			18 years old

			19 years old
			20 years old

For more information including the EPSDT Coordinators address and phone numbers, please visit the website: **www.state.tn.us/tenncare/tenndercare** or call 1-866-311-4287.

TENNCARE COVERAGE

Covered Services

Covered services are determined by the TennCare Bureau and are subject to change. For the most up-to-date information, consult the TennCare Bureau's website at www.state.tn.us/tenncare/members/Tcbenefits1.htm. Inquiries concerning specific covered services should be addressed to the participant's Managed Care Organization (MCO).

The current TennCare program is really two programs. There is TennCare Medicaid, which is for persons who are Medicaid eligible, and TennCare Standard, which is for persons who are not Medicaid eligible but who have been determined to meet the state's criteria as being either uninsured or uninsurable and did not meet the criteria for disenrollment in June 2005. TennCare Standard enrollees with family incomes at or above poverty are required to pay premiums and co-pays, however. Co-pay information is available on the TennCare website at www.state.tn.us/tenncare/members/copays1.htm.

TennCare services are offered through several managed care entities. Each enrollee has a Managed Care Organization (MCO) for his primary care and medical/surgical services, a Behavioral Health Organization (BHO) for his mental health and substance abuse treatment services, and a Pharmacy Benefits Manager (PBM) for his pharmacy services.

Children under the age of 21 are eligible for dental services, which are provided by a Dental Benefits Manager (DBM). Enrollees are allowed to choose the MCO they wish from among those available in the areas in which they live.

In addition to the TennCare managed care programs, the Bureau of TennCare administers certain long -term care services. These include care in Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), as well as several Home and Community Based Services (HCBS) waiver programs which serve as alternatives to long-term care. The Bureau also handles Medicare cost-sharing payments for eligible individuals.

Eligibility Begin Dates

Effective May 1, 2007, due to the TennCare waiver, Medicaid eligibility begins the date of application or the date all eligibility requirements are met, whichever is later, for all categories of coverage.

Previously retro coverage was given to the institutionalized and SLMB categories; however, effective May 1, 2007 retro coverage has been eliminated.

Medicaid eligibility for institutionalized individuals and SLMB may begin up to three (3) months prior to the month of application.

Co-Payments

TennCare co-payments became effective August 1, 2005. Co-pays are due at the time of service and are collected by the health care provider. Pharmacy co-pays apply to all TennCare Standard enrollees as well as non-institutionalized Medicaid adults who are eligible to receive pharmacy services in the TennCare Medicaid program. The amounts are $0 for generic drugs and $3 for brand name drugs. There are no annual out-of-pocket maximums. Pharmacy co-pays do not apply to family planning services, pregnant women, enrollees in long term care institutions (including HCBS) or receiving hospice care.

TennCare Medicaid eligibles are exempt from non-pharmacy co-pays. Preventive services are also exempt. Co-pays for TennCare Standard enrollees with incomes at or above 100% of the poverty level are similar to commercial co-pays. The amount of the co-pay is based on the percent of FPL and type of service. To encourage good preventive health habits, there are no co-pays for preventive care visits, such as, well-child visits, immunizations, check-ups, PAP smears, prostate examinations, and mammograms. There are no deductibles or annual out-of-pocket maximums which apply to persons with co-pay obligations. Go to the TennCare Website for more information on co-pays www.state.tn.us/tenncare/members/copays1.htm.

Out-Of-State Services

Legal Base: 42C.F.R. 431.52

Prior approval by the MCO is required in all but emergency situations including non-emergency medical treatment.
If the Bureau of TennCare approves the extension of Medicaid vendor payments to an out-of-state long-term care facility, observe all vendor payment eligibility requirements and procedures as cited in the chapter entitled Institutionalized Individuals Budgeting.

Reimbursement by MCOs for treatment outside of Tennessee is not available UNLESS it is 'medically necessary' and,

- The care/treatment is not available in Tennessee and the client's attending physician provides written substantiation of that fact; OR
- The care/treatment was provided as the result of an emergency or due to other extenuating circumstances such as the endangerment of the recipient's health if he/she were required to travel to his/her state of residence for treatment; OR
- It is general practice for individuals in a particular locality to use medical resources in another state; AND
- The MCO approves the out of state care before treatment begins EXCEPT for emergency care.

The TennCare Card

- TennCare cards are issued by the assigned MCO.
- The TennCare card is mailed to the eligible individual at the home address reflected in the DHS system.
- When the individual/family has no fixed address or post office box (homeless, living in automobile, etc.), the TennCare card may be mailed in care of the county DHS office address.
- The TennCare card is mailed to the long term care patient at the LTCF and/or to the authorized representative
- Lost or Stolen TennCare Card: Refer the individual to his/her assigned MCO for card replacement.

Important TennCare Phone Numbers

Family Assistance Service Centers 1-866-311-4287
- To apply for TennCare, disenrollment information,
- report a change, make an appointment

TennCare Solutions 1-800-878-3192
- To file an appeal about medical or prescription problems

TennCare Advocacy Program 1-800-722-7474
- For help with other health-related care

Tennessee Health Options 1-888-486-9355
- If you do not have health insurance and are losing TennCare

TennCare Partners Advocacy 1-800-758-1638
- If help is needed with mental health or alcohol treatment
- TTY or TDD Phone Calls 1-800-772-7647

Foreign Language Phone Lines
- Spanish Line 1-866-311-4290
- Arabic/Kurdish Line 1-877-652-3046
- Bosnian Line 1-877-652-3069
- Somali Line 1-877-652-3054

THE QUALITY CONTROL REVIEW PROCESS

The Quality Control Review Process

Federal Medicaid regulations provide for the establishment of a Medicaid Quality Control System designed to reduce erroneous expenditures by monitoring eligibility determination, third party liability activities and claims processing. The latter two items are the responsibility of the department that oversees the Bureau of TennCare and monitoring is conducted by that agency. Eligibility determination is monitored by the Administrative Review section of the Department of Human Services. That section, usually referred to as Quality Control (QC), is responsible for monitoring eligibility determinations for the three assistance programs administered by the Department. Food Stamps, Families First (previously AFDC) and TennCare Medicaid.

The monitoring of TennCare Medicaid eligibility determinations is conducted during two 6-month sampling periods each year – April through September and October through March – and includes a statistical sampling of both active TennCare Medicaid cases and negative case actions (denials and terminations). The QC Section must review each case selected in the statistical sample within 40 days to identify any eligibility errors, verify eligibility information by field investigation* including personal interview for both active cases and negative action cases, and submit monthly and summary reports on eligibility case reviews.

[*Field investigators have been waived effective 10/97]

The results of the eligibility review are reported to the Center for Medicare and Medicaid Services (CMS), the Federal Agency responsible for the administration of the Medicaid program.

The amount the federal government contributes to the State for its Medicaid program (referred to as Federal Financial Participation or FFP) is adversely affected by the State exceeding its target error rate. The target error rate is set by CMS and is based on the rate of eligibility payment errors detected by the TennCare Medicaid Quality Control System during a review period. An eligibility error occurs when TennCare Medicaid coverage is certified or payment has been made for a recipient who:

Was ineligible when certified or when he/she received TennCare Medicaid reimbursement services; OR

Is a member of a Medically Needy coverage group and had not incurred medical expenses equal to the amount of his excess income when he/she was certified or received covered services.

The Caseworker's Responsibilities

Legal Base: 42 C.F.R. 431.800f
Subpart P

Caseworker responsibilities in the Quality Control review process are limited to:

- Providing the application for assistance (HS-0169) which is identified by the Statistical Sample, within 24 hours of QC's request.

- Reviewing any QC finding and either filing a formal exception to the finding/recommendation within 15 days of receipt or taking any action necessary based on the QC report.

Procedures when Case requested for QC Review

- Complete any unfinished action based on the information available at the time of the request.

- Make sure all information pertinent to the case is updated in the history section of the data base.

- Identify related cases (active or inactive) of other household members and forward any HS-0169s along with the requested case.

- Do not inform the client that his/her case has been selected for review. Confine contacts to matters related to continuing eligibility and case maintenance.

- If an action must be taken on the case, notify the Director of Administrative Review with the action.

- Do not discuss the case with the QC Reviewer who must rely solely on the case record information in the evaluation and review process.

How to Take Exception to A QC Finding

If there is a disagreement with the Quality Control review finding, contact the Program Supervisor by telephone to report case circumstances and the reasons for disagreement. Send the Program Supervisor a written statement and copies of applicable supporting evidence immediately following the telephone call.

If the Program Supervisor agrees with the findings, he/she will contact the District Director by telephone to report the disagreement and follow-up this call with written supporting evidence.

After review, if the District Director agrees with the caseworker, Field Supervisor, and Program Supervisor, he/she will immediately refer the case to the Director of Administrative Review for a QC re-evaluation.

NOTE: Any Exception to QC finding must be made with the Director of Administrative Review with in the 15-day limit. Prompt action at each phase of this process is required.

The 15-day rebuttal period may be reduced near the end of the 6-month sampling cycle.

If either the Program Supervisor or the District Director disagrees with the caseworker's findings (i.e., agrees with QC), the exception will proceed no further. If an error has occurred, observe standard reporting procedures.

TENNCARE MEDICAID AND TENNCARE STANDARD ELIGIBILITY ERRORS/OVERPAYMENTS

Policy

Applicants declare on the Family Assistance application form that the information provided to DHS and used to determine eligibility is complete and accurate, "I declare under penalty of perjury that the answers and information I have given on this form and will give in my interview are true, and that all persons applying for or receiving aid are U.S. citizens, legal aliens or eligible immigrants". Recipients are also required to report changes in circumstances that affect eligibility. For TennCare Medicaid changes must be reported within 10 days. For TennCare Standard, changes must be reported within 30 days. If a client intentionally fails to provide correct or complete information or fails to timely report a change that would have caused ineligibility or would have caused a premium or higher premium responsibility for TCS, DHS is required to report the case circumstances to the Office of Inspector General for TennCare Fraud and Abuse (OIG).

For purposes of this section, an error based on suspected fraud occurs under one of the following conditions:

- Failure to report income or resources that would have made recipient ineligible for TennCare Medicaid;
- Failure to report income or resource changes that would have caused Medicaid ineligibility for nursing home patients or would have caused increased patient liability;
- Failure to report income changes that would have caused or increased TCS premiums;
- Failure to report insurance or access to insurance for TCS;
- Failure to report changes in household composition or residency which causes ineligibility such as incarceration, moving out of state.

DHS has responsibility for the identification and reporting of these eligibility errors to OIG.

Caseworker Responsibilities

An error may be identified in several ways, including but not limited to:

- During an annual review;
- At the time a case action is prompted by the client's report of a change of circumstances;

- At the time of an Expected Change or follow-up;
- As the result of a QC finding;
- As the result of data matching;
- As the result of information reported by a third party.

Errors are classified in one of the following ways:

- **Suspected Fraud** - When a client knowingly withholds or falsifies information pertinent to his/her eligibility;
- **Lack of Understanding** - When the error is the result of a failure to report information or the report of misinformation and there is no evidence the client intended to commit fraud.
- **Administrative Error** - An administrative error occurs under one of the following conditions:
    - The agency (DHS caseworker) is in possession of pertinent information but fails to take the appropriate action OR
    - The agency has the information but cannot act promptly due to the limitations of administrative procedures OR
    - The recipient leaves the long term care facility (by death or another living arrangement) prior to use of the full quarter's non-covered medical expenses (Item D) income deduction.
- Currently the only type of error being reported to the Office of Inspector General is Suspected Fraud.

How to Report TennCare Medicaid or TennCare Standard Eligibility Errors

A form has been created to refer potential TennCare Medicaid and TennCare Standard suspected fraud cases to Department of Human Services Office of Inspector General office for investigation. Only those potential claims that are the result of client error are to be referred. Staff should no longer use Claims Online Tracking System to pend any TennCare Medicaid and TennCare Standard potential suspected fraud claims. A copy of the Report TennCare Recipient Fraud or Abuse form can be located in the GroupWise Default Library with the title of *FA Report TennCare Recipient* or on the DHS Intranet site, http://www.intranet.state.tn.us/dhs/forms/forms.htm within the Family Assistance Program column Form Number HS 2869 titled *FA Report TennCare Recipient Fraud or Abuse.* Once completed, the form is to be returned electronically, by fax, or by mail to:

Edie Knapstein
Director, Office of Investigations
3rd Floor – Citizens Plaza Building

400 Deaderick Street
Nashville, Tennessee 37248
FAX (615) 313-6615
E-mail address: edie.knapstein@state.tn.us

Any documentation which supports the fraud allegation should also be sent by mail or fax. Please be sure the supporting documentation includes sufficient identifying information so it can be correctly associated to the appropriate client. Staff should only refer potential fraud cases that are a result of intentional client error and/or authorized representative's error.

Once the referral form is complete, CLRC should be documented on the database with the circumstances surrounding the suspected fraud information.

NOTE: Claims for agency/administrative errors or unintentional client errors are currently not pended and this form is not intended for that purpose.

The DHS Investigations section will work with the Office of Inspector General for TennCare Fraud and Abuse to determine which referrals are processed. Please do not mail or send the HS-2869 Form directly to TennCare OIG. It must be reviewed by DHS Investigations first.

TENNCARE STANDARD

INTRODUCTION

Tennessee has operated the Title XIX Medicaid program under a Section 1115 waiver since January 1994. Some services, such as long-term care, are still provided pursuant to the Medicaid State Plan.

The TennCare program became effective January 1, 1994. The General Assembly joined then Governor Ned McWherter to provide access to "affordable comprehensive health care coverage for virtually every Tennessean." The state believed that enrolling every Medicaid recipient into a managed care environment would produce significant savings. With these savings, the state would offer coverage to Tennesseans without access to employer-sponsored health insurance.

The term "TennCare" refers both to the single State Medicaid agency for Tennessee (the TennCare Bureau) and the TennCare Program which provides health coverage to eligible Tennesseans.
Effective July 1, 2002, Tennessee implemented a TennCare waiver that divided TennCare into two separate programs: TennCare Medicaid and TennCare Standard (TCS). The Department of Human Services (DHS) was given the responsibility of determining eligibility for both programs. Prior to July 1, 2002, DHS determined eligibility for TennCare Medicaid only.

Eligibility criteria for the TennCare Standard program differed from that of TennCare Medicaid in several ways. **TennCare Standard enrollment was open** to both uninsured and uninsurable individuals who, after meeting all technical requirements, also met income requirements and had no group health insurance or access to it. In addition, some adults and some children applying for TennCare Standard had to prove their medical eligibility with a qualifying health condition that essentially made them uninsurable.

Effective April 29, 2005, **enrollment was closed** for new applicants to certain TennCare Medicaid and all TennCare Standard categories. The Centers for Medicaid and Medicare Services (CMS) approved TennCare's modified waiver allowing the state to close enrollment to all applicants for TennCare Standard and to close enrollment for non-pregnant Medically Needy adults age 21 and older. This meant that non-pregnant adult applicants who applied for Medicaid after 4:30 PM on April 29, 2005 and who would only qualify if eligible as Medically Needy were not approved. This also meant that no applicant, adult or child, who applied after 4:30 PM on April 29, 2005, could be approved for TennCare Standard.

Effective June 6, 2005, **disenrollment** began for adults in TennCare Standard categories. The Centers for Medicare and Medicaid Services (CMS) approved TennCare's modified waiver request to disenroll currently eligible TennCare Standard adults, age 19 and over, and currently eligible non-pregnant Medically Needy Medicaid adults, age 21 and older. In preparation for the disenrollment process, DHS conducted ex parte reviews of all TennCare Standard adults. As a result of the ex-parte reviews as well as the Request For Information (RFI) process

implemented, some TennCare Standard adults qualified for open categories of TennCare Medicaid and were able to continue their eligibility as TennCare Medicaid enrollees.

Note re: the Medically Needy slated for disenrollment:
Due to significant legal relief from previous restrictions imposed by the Grier Consent Decree, the action to remove all currently eligible non-pregnant Medically Needy Medicaid adults age 21 and older was stopped in August 2005. With the exception of Medically Needy dual eligibles, existing non-pregnant MN adults remain eligible; however, no new applications are being accepted for these Medicaid categories. Non-institutionalized Medically Needy dual eligibles, those with Medicaid and Medicare, began a review process in late November 2005. Since these individuals have health coverage through Medicare Part A and B, and because they have access to prescription drug coverage through Medicare Part D as of January 1, 2006, they are no longer eligible as MN. If the review of their circumstances indicates eligibility in an open categorically needy Medicaid category, they may continue to be Medicaid eligible. If not, Medicaid coverage will end after advance notice is given.

Children who are current TennCare Standard recipients can remain eligible until they reach the age of 19; however, no *new* applications are accepted for TennCare Standard for children. Children up to age 19 who are terminated from TennCare Medicaid must have their eligibility considered under the Medicaid Rollover provisions of TennCare Standard. Children found eligible through the rollover process are the only individuals who can be considered new enrollees to TennCare Standard.

The next section will outline the eligibility guidelines for TennCare Standard. Although new applications are not being accepted for TennCare Standard, children under age 19 can remain as eligible participants of TennCare Standard and may also be enrolled in TennCare Standard based on Medicaid Rollover status. This information is pertinent to those individuals.

ELIGIBILITY GUIDELINES

Since TennCare's inception in 1994, eligible individuals were enrolled in TCS only during periods of open enrollment. Exceptions to this rule included the enrollment of children to the program as "Uninsured or Uninsurable" and the enrollment of adults as "Uninsurable". Prior to April 29, 2005, applicants could enroll in TennCare Standard during periods of closed enrollment if they had income less than 100% of the FPL and had health problems that kept them from getting health insurance. These individuals are now called "Medically Eligible" (ME) rather than Uninsurable. As of April 29, 2005, however, this option of TennCare Standard enrollment for adults is no longer available. Currently only children up to age 19 who are terminated from TennCare Medicaid may be potentially eligible for TennCare Standard as uninsured when family income is under 200% of the FPL or may be considered for TennCare Standard as medically eligible when family income is at or above 200% of the FPL, as a part of the Medicaid Rollover process.

APPLICATION PROCESSING

The Application Form

Because enrollment to TCS is closed to all new applicants, any DHS application form (HS-0169) received will be used to process applicants for Medicaid categories only. As of April 29, 2005, new applicants are no longer screened for TennCare Standard.

Comparison of TennCare Medicaid and TennCare Standard

Benefits Comparison

The key similarity between TennCare Medicaid and TennCare Standard for children is the benefit package since children have the same benefit package based on medically necessary services, whether they are enrolled as TCS or Medicaid. Effective August 1, 2005, prescription drug coverage was eliminated from the benefit package for TennCare Standard adults. Although TennCare Standard adults have subsequently been disenrolled from the program, it is possible that a TCS adult may retain eligibility pending an appeal. In cases like these, the TCS adult benefit package can reflect no prescription drug coverage. Non-institutionalized Medicaid adults (age 21 and older) have a benefit package that includes a five prescription limit effective August 1, 2005. Institutionalized Medicaid adults have no pharmacy limit in their benefit package.

Eligibility Comparison

- Insurance or Access to Group Health Insurance

  Having insurance or access to group health insurance does not prohibit enrollment in TennCare Medicaid. Generally, persons who have health insurance (including Medicare) or who could get group health insurance through their employment or a family member's job are not eligible for TennCare Standard.

- Income Limits

  For a child under age 19 who is losing Medicaid and who is rolling over to TennCare Standard, income is a factor in determining if the child (when otherwise eligible) is eligible for TennCare Standard as uninsured (family income must be below 200% FPL). If family income is at or above 200% FPL, the child must also be determined medically eligible to qualify for TennCare Standard in the rollover process. It can be generalized then, that income itself is not a barrier to a child qualifying for TennCare Standard in the rollover process. However, there are set income limits for the different categories of TennCare Medicaid.

- Resource Limits

  Although there are resource limits for most Medicaid categories, there is no asset test (i.e., resource limit) for TennCare Standard.

- Enrollment

  A person may apply for TennCare Medicaid at any time. In addition, he/she may enroll in most TennCare Medicaid categories whenever he/she meets the eligibility criteria.

  Prior to April 29, 2005, persons could also apply for TennCare Standard at any time. As of April 29, 2005, only children under age 19 who are terminated from TennCare Medicaid have the opportunity to be considered for enrollment in TennCare Standard, at the point that they lose Medicaid. .

- Cost Sharing

  Children under 21 enrolled in TennCare Medicaid do not have cost sharing responsibilities. Effective August 1, 2005, non-institutionalized TennCare Medicaid adults do have pharmacy co-pay responsibilities except for generic drugs. TennCare Standard enrollees at or above 100% of the poverty level pay both a premium for their TennCare coverage and co-pays for most TennCare covered services.

COVERAGE GROUPS

State Rule: 1240-3-3
Proposed: 1200-13-13-.01

Effective July 1, 2002, DHS became responsible for determining eligibility for the coverage groups listed below.

Tennessee residents who apply for Medicaid or for redetermination of eligibility (review).

Individuals applying for TennCare Standard either as new applicants or for redetermination of eligibility (renewal). As of April 29, 2005, no new applicants may be approved for TennCare Standard.

GENERAL REQUIREMENTS

Please refer to the Chapter on General Administrative Procedures in this Manual for detailed information on the following topics:

- Confidentiality
- Federal non-discrimination laws
- Accommodation requirements

Financial Requirements

Resources

There is no resource test for TCS. Verification of resources is a requirement for certain TennCare Medicaid categories, but failure to provide this information does not prevent a case

from continuing to TCS eligibility determination. This only applies currently to children under age 19 being processed as a Medicaid Rollover.

Income

At renewal, the maximum income limit for children under age 19 currently enrolled in TCS as uninsured is under 200% of the FPL (Federal Poverty Level). When a reported income change causes family income to equal or exceed 200% FPL, the child must be immediately processed for Medically Eligible (ME). Children whose family income is at or above 200% FPL at renewal must be processed for a Medical Eligibility (ME) Packet. For coverage to continue, the ME packet must be timely returned, and the child must qualify as medically eligible.

Premium and Co-pay Responsibility

All eligible TCS enrollees with income that is at or above 100% of the FPL have cost-sharing responsibilities. Premiums are based on countable family income and the number of eligible family members in the household and are computed on a sliding scale. The number of TCS eligible individuals is used to decide the individual or family premium level. ACCENT will:

- Compute the premium amount;
- Determine if the premium is for an individual or family; and
- Transmit this information to TennCare.

If only one person is eligible, the individual premium is calculated (even though there may be more budget group members). If there is more than one eligible TCS member in the group, the family premium is calculated. Groups with income less than 100% FPL have no premium responsibility.

The TennCare Bureau mails monthly premium notices to those required to pay a premium. The TennCare Bureau also determines when case closure is required because of nonpayment of premiums. The DHS caseworker will receive notification of each "dunning" closure through an ACCENT alert and should immediately close the TCS case on ACCENT.

If an enrollee calls with questions about their premium and you are not able to answer the questions, please refer the enrollee to the premium unit at TennCare. The toll free number is 1-866-683-6554 or local to Davidson County is 253-7055.

TCS members with income at or above 100% FPL also have a co-payment for different services.

Co-pays for pharmacy benefits for name brand drugs are required for individuals eligible for TCS with income at or above 100% of the FPL. There is no co-pay for generic drugs.

Any changes in the family income of a currently enrolled individual should be entered in ACCENT so that the premiums/co-pay will be adjusted in the system accordingly.

Earned Income

Earned income is defined as the compensation an individual receives:

- For the performance of services as an employee; or
- As a result of his own efforts; or
- Through self-employment.

Earned income for TCS is counted using the same method as outlined in this Manual in the Chapter on Income and the Chapter on Treatment of Income and Budgeting. Wages are considered available to the individual when they are received, credited to the individual's account, or set aside for the individual's use.

Deferred wages are paid at a time later than they normally would have been paid. If wage payments are deferred due to circumstances beyond the employee's control, consider the payment of earned income when it is actually available to him.

Verification of Earned Income

The items listed below can be used to verify earned income:

- Paycheck stubs representing two months of income
- A statement from the employer that includes the date earnings were paid, the gross earnings, the specific identification of any withheld earnings, and tips reported (if applicable).
- Copy of the most recent Federal income tax return, if self-employed.
- Copy of profit/loss statement if partnership income
- Copy of rental/lease agreement
- Client statement when none of the above is available.

Earned Income Disregards

Disregard the following from each family member's gross earnings, as appropriate:

- The earnings of a student the first six months per calendar year;
- The earnings of a part-time student who is not employed full time;
- $90 per month for work expenses for each wage earner; and/or
- Dependent care expenses based on the age of the child up to $200 per month per child, if verified.

More details on the above verifications may be found in the Chapter on Treatment of Income and Budgeting in this Manual.

Unearned Income

Unearned income is defined as money an individual receives that

- Is not the result of his current work efforts, but
- Accrues to him as the result of investments, gifts, contributions, inheritance, or previous work efforts.

More information is available in the Chapter on Income in this Manual.

Excluded Unearned Income

For purposes of TCS, the ONLY type of income of required budget group members that is excluded from the budget is Families First and SSI cash assistance.

Unearned Income Verification

The items listed below can be used to verify unearned income. This list is not all-inclusive. Refer for more information to the Chapter on Income in this Manual.

- Social Security recipients - Use information on Data Exchange, Clearinghouse or SOLQ;
- VA recipients - copy of check, award letter, or bank statement, if direct deposit
- Rental/lease agreement. (For whether to treat this as earned or unearned, please refer to the Chapter on Income in this Manual.)
- Current copy of federal income tax return
- Inheritance - copy of will or statement from probate court.
- Contributions - written statement from the party making the contributions. The statement should include the amount and frequency of income.
- Alimony/child support: - Use the information on TCSES, a copy of the agreement awarding income, photocopy of check, a written statement from the individual paying support or alimony, or contact the court clerk.
- Unemployment - Use the information on Data Exchange, Clearinghouse, photocopy of the actual check, or award letter.

Unearned Income Disregards

Disregard up to $20 from all unearned income. If unearned income is less than $20, then only deduct the amount of the income.

Truncating Income

All cents are dropped at each step of the budget. ACCENT automatically does this.

Budget Group

Once a child has been determined no longer eligible for TennCare Medicaid, and the case has been authorized on AEWAA, the ACCENT TennCare screens will appear. Children under age 19 being processed as Medicaid Rollover for TennCare Standard (as indicated on AEITC) will be the "target individuals" for TCS. Parents in the home are required members of the BG but must be designated as "other" members. Designation of individuals as either "target" or "other" impacts TCS eligibility as well as premium and co-pay amounts. (See group selection below.)

Budget Group Identification

- Individuals Who are Required to be Included

    - Children under age 19 who are losing Medicaid eligibility are included in the TCS group.

    - Legal parents and their minor children (under age 19 for TCS) group together although only the children are "target" individuals. If the child lives with an alleged parent (who should be designated on AEIHH as the father), the child will "draw" the alleged parent into the TCS group. In those instances, the alleged father's income will count in the TCS budget, even if the child is not a "target" member of the TCS case.

      EXCEPTION: Do not include alleged parents if the child or the alleged parent receives Families First or SSI cash benefits.

    - Spouses are required to group together, so the possibility of a stepparent being required in the group exists. In that instance, the stepparent's income will count in the TCS budget, even though the spouse is not a "target" member of the TCS case.

      EXAMPLE: When a MA T (pregnant) mother is an "other" in a child's TCS case, the stepfather is also grouped as an "other" and his income is countable.

      EXCEPTION: Do not include the stepparent if the spouse or the stepparent receives Families First or SSI cash benefits.

    - Individuals who are not TennCare Medicaid eligible but who are required members must be included in the budget group for the purposes of counting income, even when they are not eligible for inclusion for TCS.

- Other individuals who are

- designated as the head of group/premium payer but who are not required to be included and whose income is not counted, such as a non-parental caretaker; **and**

- Medicaid-eligible individuals (other than SSI and Families First recipients) who are within the specified degree of relationship whose income must be counted (such as a Medicaid-eligible parent).

- Individuals Who MAY Be Included in the TCS Budget Group

  - Family members who are within the specified degree of relationship and who are TennCare Medicaid eligible may be included.

    - A non-parental caretaker within the specified degree of relationship if this is to the advantage of the AG. These caretaker relatives are not eligible for benefits since enrollment is closed.

- Individuals Who Are NOT Included in the TCS Budget Group

  - Families First and SSI cash recipients are not included in the TCS group.

  - When a child turns age 19, he/she is no longer considered a child for TCS purposes and may no longer be included in a TCS case with siblings.

    - close the 19-year-old in the existing TCS case;

    - obtain a completed application signed by the 19-year-old; and

    - determine if he/she is eligible in any TennCare Medicaid category. (A 19-year-old is considered to be a child up to age 21 for purposes of determining Medicaid eligibility and may qualify for a spend down.)

Budget Group Selection

Select the Budget Group from among the "Target" children and "Other" individuals.

- The "Target" children are those closed for TennCare Medicaid (was not eligible) and are being processed as Medicaid Rollovers.

- The "Other" individual is one who:

  - is TennCare Medicaid eligible in the family group but whose income is required to count toward the target individual;

    OR

  – is being designated as head of case but who is not required to be included in the aid group, such as a grandmother or uncle;

    OR

  – is required to have his/her income counted in the TennCare Standard budget.

TENNCARE MEDICAID ROLLOVERS

An individual who is losing TennCare Medicaid eligibility must have an opportunity to be processed for enrollment in TennCare Standard as a "Medicaid Rollover". A Medicaid Rollover is treated as a renewal case and can be opened for TCS even when enrollment is closed. As of April 29, 2005, only children under age 19 who are terminated from TennCare Medicaid are considered in the Medicaid Rollover process. If otherwise eligible, a child whose family income is under 200% FPL may be opened as uninsured when qualifying due to Medicaid Rollover. Those whose family income is at or above 200% FPL must first be processed as ME.

NOTE: Individuals are not eligible as "TennCare Medicaid Rollovers" if their TennCare Medicaid benefits were:

- based on presumptive eligibility;
- for emergency services for Undocumented Aliens; or
- based on their refugee status.

To easily identify cases that are not TennCare Medicaid Rollovers, look at eligibility in the TennCare system.

Presumptive Eligibility Breast/Cervical Cancer	Program Code 95
Presumptive Eligibility Pregnant Women	Program Code 50
Emergency Services For Undocumented Aliens	Program Code 34, with Category Code 2500
Refugees	Program Code 30, with Category Code 2500

These individuals may reapply for TennCare Medicaid. If technically eligible, a Medicaid rollover child whose family income is under 200% FPL may be opened for TCS as uninsured.

TennCare Medicaid Rollovers who are technically eligible for TCS, but whose family income is at or above 200% FPL will be processed for Medically Eligible determination. TennCare Standard coverage for individuals who are eligible as TennCare Medicaid Rollovers starts when the TennCare Medicaid coverage ends so that there is no gap in coverage.

Processing Medicaid Rollover Cases For Children Under Age 19 Losing Medicaid

Medicaid Closures Based on Reported Changes

When a reported change results in closing of Medicaid coverage for a child under age 19, processing for TennCare Standard as a Medicaid Rollover is required even if the child is not eligible technically. If a child losing Medicaid has access to insurance for example, a transaction

to deny the child for TCS with the correct denial reason code ensures that a notice is created from TennCare which informs the family of the reason for denial and gives appeal rights.

EXCEPTIONS:

- Do not process a child for Medicaid Rollover if the client requested Medicaid closure in writing.

- Do not process a child for Medicaid Rollover if the Medicaid closure is due to death.

- Do not process a child for Medicaid Rollover if the Medicaid closure is due to the child becoming eligible for SSI Medicaid.

An application is not required to process a Medicaid Rollover based on a reported change, but all required verifications must be provided in order to open a child for TCS as a Medicaid Rollover. This may include income verification, and access to insurance verification.

Whenever possible, the authorization to approve or deny TCS should be done the same day as the closure for Medicaid. If this is not possible due to outstanding verifications, and the child is later approved, be sure that the application date used for the TCS approval is a date prior to the Medicaid end date on the TennCare system.

In situations when an ME packet must be requested due to family income at or above 200% FPL, there may be a longer period of time between the Medicaid closure transaction and the final ME transaction if the child is approved for TCS coverage as ME. Again, check to be sure the TCS application date is prior to the end date of Medicaid coverage in order to prevent any gap in coverage.

Medicaid Closures Based on Changes During the Annual Review

If a child under age 19 loses Medicaid eligibility due to changes reported during the annual review, sufficient information must be obtained at that time to process the child for TCS as a Medicaid Rollover. As above, even if information indicates that the child does not qualify for TCS, for example, due to access to insurance, a TCS transaction to deny the child for TCS is required using the appropriate denial reason code to ensure that a notice is created from TennCare which informs the family of the reason for denial and gives appeal rights.

An application is not required when processing for TCS based on closures during review.

EXCEPTION: When the Medicaid case is closed due to failing to complete the review or failing to provide required verifications, a new application must be filed prior to the end date of Medicaid in order for TCS eligibility as a Medicaid Rollover to be determined. Applications received after the end date of Medicaid cannot be used to determine Rollover eligibility, but will be treated as Medicaid applications.

When approving a "TennCare Medicaid Rollover" case at the time of TennCare Medicaid closure, authorize the TCS case without waiting for the TennCare Medicaid end date to display in Interchange.

Medicaid Rollovers for Uninsured Individuals and Medically Eligible Individuals

Uninsured Individuals

Since enrollment closed on April 29, 2005, the only individuals who may be added as TennCare Standard Uninsured persons are children under age 19 losing Medicaid and with no insurance or access to insurance, and whose family income is under 200% FPL.

Medically Eligible Individuals

Since enrollment closed on April 29, 2005, the only individuals who may be added as TennCare Standard Medically Eligible persons are children under age 19:

- who are losing Medicaid and
- who have no insurance or access to insurance, and
- whose family income is at or above 200% FPL, and
- who have medical problems that prevent them from getting health insurance.

Children rolling over to TCS who must be processed for ME must receive an ME Packet, return it within the required timeframe, and meet the criteria for ME as determined by the TennCare Bureau. The process is described below.

Existing ME Eligible Children on TennCare Standard

Children who are already eligible based on meeting ME criteria may currently remain eligible without a new ME determination. At some point in the future, a new determination may be required, which would occur at the annual renewal.

A child currently enrolled in TCS as Medically Eligible may have had to meet initial family income requirements of under 100% FPL upon application. Any subsequent increase in family income does not affect eligibility, but may affect premium or co-pay responsibilities. The exception would be a child considered a grandfathered-in child, who may have access to insurance and remain eligible. See additional information on this group of children in a later section.

Determining ME Eligibility – TennCare Requirements

The TennCare Bureau or their designee determines if children with health problems meet the Medically Eligible criteria. This determination is based on information and verification provided by the applicant/recipient in the Medically Eligible Packet, or by existing and current medical encounter data in the TennCare system.

An ME Packet is a multi-page document that must be completed regarding the child's physical and/or mental health. Corroborating verification from the physician or mental health provider must be provided.

Upon DHS' request, TennCare mails an ME Packet to the individual to be completed and returned within 60 days of the mail-out date. The ME Packet includes instructions to the individual as to what he/she must provide and the deadline for submitting the information. An additional 30 days may be granted by TennCare if an individual returns an **incomplete** packet within their 60 days. Individuals failing to timely return the ME packet will be denied.

Upon receipt of the completed ME Packet, TennCare determines ME eligibility in one of three ways:

- The TennCare Bureau accepts a physician's attestation that the individual's health problems are included in an approved list of diseases/conditions that constitute Medical Eligibility.

- For those diseases/conditions that are not included in the approved list, TennCare's internal underwriters will review submitted medical records attesting to the condition to make the ME determination.

- Qualifying mental health conditions can be verified with a mental health assessment made by a Community Mental Health Center, who then submits this information to TDMHDD for confirmation and processing before going to TennCare.

Once TennCare makes a decision regarding ME eligibility, the TennCare system (Interchange) sends the ME decision to ACCENT. The DHS caseworker will receive an ACCENT alert to either approve or deny the case for ME. Individuals who are denied receive a notice from the TennCare Bureau which includes appeal rights.

DHS ME Responsibilities

The DHS caseworker processes the TennCare Medicaid closure and considers the individual for TennCare Medicaid Rollover. Follow the procedures listed in this section to process a Rollover case when family income is at or above 200% FPL, there is no access to insurance, and ME processing is required.

A TCS eligibility determination might not be made during an interview with the applicant/recipient. Therefore, these individuals may not be aware that an ME packet will be mailed to them nor that it must be returned within 60 days. In those instances, on the same day that the TCS denial/closure is authorized, send a CNFF notice to the client. Use the following text to explain about the ME process:

> *"Your child cannot get TennCare Standard. But, your child may still be able to get TennCare if he has health problems that keep him from getting health insurance. We call this "Medically Eligible" or ME.*

TennCare will mail an M.E. packet for you to fill out. You should get it about five working days after you get this letter. If you do not, call the Family Assistance Service Center at 1-866-311-4287. (This is a free call.) They can send another packet to you."

The DHS county office is also responsible for tracking and processing ME Packets that have been mailed to the applicant/recipient when he/she states he has not received an ME Packet. Follow the steps listed below regarding tracking/replacing ME Packets.

Instruct the client to return the ME packet within 60 days, even if he/she cannot provide all of the required verifications. See "Incomplete Packets Received At TennCare" below for details.

PROCESSING MEDICALLY ELIGIBLE INDIVIDUALS

Processing Children for ME Packets

Basic Processing Requirements for ME for Children Who Are Rolling Over from Medicaid

- Child must be closing out for Medicaid coverage
- Child must be under age 19
- Child must not have access to or have insurance
- Family income must be at or above 200% FPL (if under 200% FPL, open as uninsured)
- To process for a ME packet, deny for TennCare Standard on ACCENT AEITG screen using reason code 509 (indicates over the income level for TCS as uninsured) is required. This alerts the TennCare system to produce and mail the ME packet.

Basic Processing Requirements for ME for Currently Eligible TCS Children when Family Income Increases to 200% FPL

- Processing a child for ME due to an income change must occur at the point the change is reported. Processing for ME may also occur during the annual renewal, if an income change becomes known at that time.
- Child must be under 19
- Child must not have insurance or access to it.

  NOTE: If child was previously open as a **grandfathered child**, and continues to have access to insurance, they are not eligible to be considered for ME. Closure is required in this situation. If access to insurance no longer exists, then the "G" grandfathered flag must be removed from ACCENT screen AEITC prior to processing for an ME packet.

- Check ACCENT to be sure child is not already open as ME. If they are, then process as an income change only.

- To process for a ME packet, close the existing TCS case on ACCENT using reason code 509 (indicates over the income level for TCS as uninsured). This alerts the TennCare system to produce and mail the ME packet.

  EXCEPTION: If processing a child for ME at renewal due to an income change, check OATS to determine if an "A" flag exists for the child. If so, an ME packet is not necessary. The existing TCS case can be closed using reason code 509 in order to open the ME for the child.

Tracking ME Packets

TCMIS system (old TennCare system on 3270) TMEH and TMEC screens are used to track the ME packet. These screens are accessed using the ACCENT case number. The screens show:

- the cut-off dates for return of the ME packet,

- date received,

- incomplete packet,

- approval or denial status of medical eligibility, and

- packet type, renewal or application.

If DHS or TennCare causes a delay that will prevent the client from returning a completed packet by the 60th day, county staff will contact the TennCare Medicaid Policy Unit.

ME Replacement Packets

DHS will hand out or mail replacement ME packets. These replacement packets may only be provided when it has been verified that an original packet was produced out of the TennCare system. In no instance should these packets be provided if no original packet was ever produced by the TennCare system.

- If an individual contacts DHS for a replacement packet:

  - verify on TCMIS that an original packet was produced;

  - verify that the "cutoff" date has not yet passed (day 60 or less) and enter the cut-off date on the Replacement Packet Cover Sheet;

  - complete the cover sheet with identifying data to include the name, SSN and case/category/sequence number, as it appears on Interchange. (The case/cat/seq is used as the control number for the replacement packets. Therefore, it is very important to use the one on Interchange.) This information will be used by

TennCare to identify the correct individual to process when the packet is returned; and

- document CLRC that the packet was either handed or mailed to the individual and the date that this was done.

- If the replacement ME Packet is handed to the individual, he/she must sign a receipt form acknowledging receipt of the packet. If the applicant/recipient sends someone else in to get the replacement packet, the individual picking up the packet must sign his/her own name on the receipt.

- Inform the individual about the due date for the completed ME Packet. The ME Packet must be submitted to the TennCare Bureau. It cannot be submitted to the DHS office. If the individual obtains the packet on the 60th day, advise him/her to submit the packet, complete or incomplete, on that same day. TennCare Bureau will determine if the packet is received timely.

- Verify that the TennCare address is correct so that future mailings will be received.

- If the cut-off date has passed and DHS or TennCare caused the delay, contact the TennCare Medicaid Policy Unit. If DHS or TennCare did not cause the delay, advise the client of their right to appeal the denial and/or to reapply. "Good cause" for failure to return a packet will be established in the appeal.

Incomplete Packets Received at TennCare

When an incomplete ME packet is received at TennCare on or before the 60-day due date, it is sent to the ME Outreach Unit in TennCare. The client is automatically allowed additional time to provide the needed information. The 60-day deadline is extended for 30 additional days (for a total of 90 days) regardless of what day within the 60-day time frame the incomplete packet was received. The ME Outreach Unit sends a letter to the applicant, informing him/her:

- that ME Packet is not complete;

- what is incomplete; and

- how to go about completing the packet.

The ME Outreach Unit also attempts to contact the client to obtain the missing information.

Only necessary parts of the incomplete packets are returned to the client. For example, if the packet is missing the client's signature, only that page of the packet will be returned for completion. If the enrollee does not complete the packet by the 90th day, the application will time out. "Timed-out" packets are returned to the client with a letter of explanation about the missed deadline, and the TennCare Bureau sends a notice to the client denying Medically Eligible.

TENNCARE STANDARD RENEWAL

Renewal is the process of determining continuing eligibility for children under age 19 who receive TennCare Standard benefits.

As of April 29, 2005, the only individuals who will remain eligible for TennCare Standard are children under age 19. These individuals will be selected for annual review/renewal of eligibility. Currently, the TennCare Bureau selects individuals to be processed for renewal, and mails a notice, instructions, verification of income and insurance form, and a renewal form for the client to complete and return to DHS by a designated 90th day. For individuals timely returning the form, coverage remains open potentially past their 90th day, until DHS completes renewal processing.

TennCare Standard Renewal Notices

- TennCare sends the initial renewal packet (notice and forms) indicating the 90th day by which the completed and signed renewal form must be received by DHS. The renewal notice is TN135.12.

- TennCare sends a reminder to those individuals who have not returned the renewal form (as documented on the OATS system), by the 30th day. This reminder again informs the client to complete and return the renewal form to DHS by the designated 90th day. The 30 day reminder notice is TN121.9.

- TennCare sends a closure notice, providing 20 days advance notice, on the 70th day to those individuals who have not returned the renewal form to DHS. They still have until the designated 90th day to complete the form and get it to DHS to prevent closure. But if the form is not received timely, coverage ends as stated in the notice sent on the 70th day. The 70 day termination notice is TN 125.12.

TennCare Standard Renewal Processing

Use of Renewal form:

- Renewal forms and the information contained in them may be used to open an individual for open categories of Medicaid if circumstances have changed and the child or family is now Medicaid eligible.

- Renewal forms may be used to determine ongoing TCS eligibility.

- Renewal forms may not be used to apply for Families First or Food Stamps. The DHS Application Form (HS-0169) must be completed to apply for these programs.

- Receipt of the renewal form must be documented on the appropriate OATS screen in order to ensure that coverage remains open until the renewal is complete.

- A renewal form received after the 90th day will be used as an application for Medicaid. The individual will have already been closed for TCS coverage due to not timely returning the form.

- A renewal form received from someone not due for renewal (is not on OATS as a renewal individual) may be treated as a reported change.

- An HS-0169 DHS application form may be used to process a renewal, however all needed elements of eligibility contained in the renewal pages must be obtained from the client. This may be done by sending request for verification form or talking with the client on the telephone to advise them of additional required information/verifications.

Interviewing/Contacting the Recipient at Renewal

There is no interview requirement for the Renewal process. However, the client may request a face to face or telephone interview to complete this process. If the client asks for an interview, remind him/her that an interview is not required for renewal and explain that the form may be mailed, faxed, or dropped off at the DHS office. The client should be advised to send in the renewal form even if an interview is scheduled. If the client does not keep the interview appointment, and the renewal form has been received, process the renewal with the information available.

Accommodations or Assistance in Completing the Renewal Form

Renewal processing is currently only for TennCare Standard children under age 19. The adult (parent or other adult caretaker) may request assistance in completing the renewal forms. This request may come through the local DHS office or the Family Assistance Service Center. An individual may be able to be helped over the phone. If not, determine if the request for assistance is due to a mental health problem or disability that may require a home visit, alternate site visit (such as the local Community Mental Health Center/CMHC), or DHS office visit and assist in making those arrangements. If assistance is needed due to Limited English Proficiency (LEP), determine if an over-the-phone interpreter can assist or if arrangements must be made for an in-person interpreter to be present. Similar arrangements can be made for the hearing impaired and the visually impaired, depending on the needs of the client.

Reviewing the Renewal Form

- Determine if the form is signed by the parent or designated caretaker for the case. If not, contact the client to obtain a signature, which is required for the form to be considered 'received' timely.

- Determine if any required information was left off the form or required verifications are not included. Contact the client or send a request for verification for any needed information/verifications, giving the client 10 days to provide this information Document such request in running record with the date of contact, or date request was sent and specifically what was requested. If client indicates assistance is needed in obtaining the needed verification, then the caseworker will assist.

- Check family composition and determine if new individuals are included or individuals are no longer in the home. If an eligible child is no longer in the home, a contact must be made to determine if coverage must be closed, or if there is a new caretaker who will be applying for the child.

- No new children may be added to an existing TCS case since enrollment is closed. This includes newborn or adopted children. If new children are included on a Renewal form, additional verifications may be needed in order to process them for Medicaid.

- Check for any change in demographic information and update on ACCENT.

- Check that name, date of birth and social security number match that entered on ACCENT. Resolve any discrepancies.

- Update income information as needed.

- Check ages of children to determine if they are under age 19. Any children who have turned age 19 may not continue to receive TCS. They must be tested for eligibility in all potential Medicaid categories as part of the renewal process.

- Determine if any children currently open for TCS may now be Medicaid eligible, based on the information contained in the renewal form. Parents or other related caretakers may also be Medicaid eligible based on information in the Renewal form. If Medicaid eligibility is established, first close the TCS case on ACCENT.

- If a client opts to decline to give resource information, and this information does not exist on ACCENT, and the child would only be eligible in a Medicaid category that has a resource limit, then Medicaid eligibility cannot be determined. The child can continue to be eligible for TCS if otherwise eligible.

Verification

During Renewal, certain information that was previously provided does not require new verification. Only information that is subject to change must be verified at Renewal.

Do Not Verify:

- SSN if previously verified

- Identity if previously verified

- Alien status if previously verified and not subject to change

- Income that can be verified through data matching (SSA, SSI, Unemployment)

- Residence if previously verified and has not changed

Do Verify at Renewal or Reported Change:

- Earned and unearned income (other than that listed above)
- Child care costs (if not provided, the expense is not allowed as a deduction)
- Insurance and access to insurance
- Alien status if subject to change
- Residence if changed

Offer of Assistance in Obtaining Verifications

If there are required verifications that are not provided with the Renewal form, the client must be contacted either by phone or by mailing verification request form. Be sure to offer assistance in obtaining needed verifications, as we do with all Family Assistance programs.

No Verification Available

As with TennCare Medicaid cases, if neither the client nor DHS can obtain the necessary information, the client's statement may be used. Document running record with all attempts to obtain required verification.

Establishing Medical Eligibility (M.E.) at Renewal and at Reported Change

M.E. already established

Children who were classified as uninsurable or M.E. due to 'encounter data' that existed in the TennCare system were opened on ACCENT initially, in 2002, as Medically Eligible. These were the children who had an 'A' flag on OATS.

Children who were opened as new applicants beginning in July 2002, meaning they had to have M.E. established in order to be approved for TennCare Standard coverage, do not have to go through the M.E. process again at this time. Likewise, children processed for M.E. at a prior Renewal do not have to be evaluated again at this time. These children should have the appropriate flag on OATS to indicate this status. If previously approved as M.E. and otherwise still eligible, they may be re-approved at Renewal using reason code 127.

Children originally eligible as uninsured whose family income is now at or over 200% FPL must be processed to see if they qualify as Medically Eligible. This must occur at the point the change of income is reported to DHS. One of three situations will exist:

Child was originally eligible as an uninsured child, and must now be processed as M.E. during renewal due to an increase in the family's income.

If OATS indicates the child has an A flag, meaning encounter data already exists you must still close the existing TCS group on ACCENT using the 509 reason code. If the encounter information is still in effect, TennCare will return a 'reverse add' alert. You may open the child as M.E. when this information is returned. If the encounter data has expired, an M.E. packet will be sent by TennCare.

NOTE: A child eligible as uninsured who qualified due to being a Grandfathered-in child is only eligible to be processed for M.E. if access to insurance no longer exists. If access to insurance still exists, closure is required when income is at or above 200% FPL.

A change is reported outside of renewal and family income is now at or over 200% FPL.

There will be no OATS information available in this situation. Close the existing TCS group on ACCENT using the 509 reason code. As above, if encounter information is in effect, TennCare will return a 'reverse add' alert. You may open the child as M.E. when this information is returned. If there is no encounter data or the data has expired, an M.E. packet will be sent by TennCare

In either situation above, when processing of an M.E. packet is required, contact with the family must be made to be sure they are aware that an M.E. packet will be mailed to them, the importance of returning it within the 60 day timeframe and to call the FASC if they have questions about completing the packet. This contact may be done by using a CNFF notice out of ACCENT. Use the following text:

> *"You cannot get TennCare Standard. But, you may still be able to get TennCare if you have health problems that keep you from getting health insurance. We call this 'Medically Eligible' or M.E.*
>
> *TennCare will mail you an M.E. packet for you to fill out. You should get it about five working days after you get this letter. If you do not get the packet, call the Family Assistance Service Center at 1-866-311-4281. This is a free call. They can send you another packet."*

Adding Individuals at Renewal

Due to closed enrollment (as of April 29, 2005) new individuals may not be added to an existing TennCare Standard group. The only exception is if an eligible child moves from one open TennCare Standard case to another. The possibility also exists that a child losing Medicaid eligibility could be added to an existing TennCare Standard case as a Medicaid rollover.

IDENTIFICATION OF RENEWAL POPULATION

The Online Appointment Tracking System (OATS) provides the primary key to identifying the renewal groups. OATS shows selected individuals/family groups who are due for TennCare Standard renewal (reverification).

Flags are used to specify certain features important to the handling the case. The flags and their definitions are listed below.

A – Deemed Medically Eligible

B – Grandfathered - In Medicare Individual (Uninsured) - no longer in use.

C – Grandfathered - In Individual (Child). See detailed description of group Grandfathered - In Child section.

D – DCS (Dept. of Children's Services) Custody Child. Reverification/renewal is the responsibility of DCS Child Benefits worker unless the child is no longer in custody.

M – Grandfathered - In Medicare Individual (Uninsurable) – no longer in use.

S – SPMI/SED (Severely and Persistently Mentally Ill /Severely Emotionally Disturbed). Special application processing accommodations need to be explored.

T – TPL (Interchange shows current health insurance)

U – Currently Uninsurable.

MANAGED CARE

TennCare health, mental health, dental and pharmacy services are all provided through managed care companies, or MCC's.

Managed Care Organizations (MCO)

There are several Managed Care Organizations that provide health care services based on geographic area. A list of these MCO's and the counties they serve is available on the TennCare website at http://www.state.tn.us/tenncare/healthplans/MCOcounties1.htm.

Selection of MCO

When an enrollee initially becomes eligible for Medicaid or TennCare Standard, they are given an opportunity to select their MCO. If no selection is made, TennCare makes a random assignment. The newly approved enrollee has 45 days to request a change of MCO. Normally all individuals in a family must have the same MCO. The enrollee's selection of MCO may be changed by TennCare if their requested MCO is closed to new enrollees. If an enrollee/family moves out of the service area of one MCO into another service area, they may select a new MCO, or TennCare will randomly assign the new MCO.

If an individual has a medical reason for requesting an MCO change outside of the initial 45 days, or outside of the selection for other family members, the individual must file an appeal with the TennCare Solutions Unit via phone **1-800-878-3192, or** fax **1-888-345-5575, or** mail to **TennCare Solutions Unit, PO Box 593, Nashville, TN 37202-0593**. A TennCare Medical Appeal form is available on the TennCare website at http://www.state.tn.us/tenncare/members/medappeal1.htm . These medical appeal forms may also be obtained at local DHS offices and through the Family Assistance Service Center.

Making the MCO Selection

Currently, no new enrollees are being added to TennCare Standard. Those children currently eligible for TCS are already assigned to an MCO. Children losing Medicaid eligibility and being processed as a rollover for TennCare Standard also already have an MCO assignment, which does not change if the child is opened for TCS.

Behavioral Health Organization (BHO)

There are two BHOs that serve TennCare enrollees. Assignment is related to the MCO assignment, so there is no selection for the enrollee. The two plans and their contact information are found on the TennCare website at http://www.state.tn.us/tenncare/healthplans/TCBHOcontacts1.htm
The BHO covers mental health and alcohol and drug abuse services for children on TCS.

Pharmacy Benefits Manager (PBM)

Pharmacy benefits are handled through TennCare's PBM which is currently First Health. Information about pharmacy benefits is available on the TennCare website at http://www.state.tn.us/tenncare/pharminfo.html. This site includes information on script limitations (which does not apply to children under age 21), the most up to date pharmacy short list (those drugs which do not count in the script limit), prior approval information and information for providers.

Dental Benefits Manager (DBM)

Dental benefits are only available to children under age 21. Dental benefits are handled through TennCare's DBM, which is currently Doral Dental of Tennessee, LLC. Information about dental benefits is available on the TennCare website at http://www.state.tn.us/tenncare/dental/memberdental1.htm. Families needing to find a dentist for their child can call Doral Member Services at 1-888-233-5935.

Once an MCO is assigned it can only be changed when a family with an active case moves out of their assigned MCO's coverage area. DHS staff can indicate on the system which MCO an individual wants when a move occurs, but this is for informational purposes only. If a new MCO is not designated in ACCENT when an individual moves out of the current MCO's coverage, TennCare will assign one. If an individual has a medical reason for requesting an MCO change, the individual must file an appeal with TennCare.

Making the MCO Selection

In order to assist the applicant to select his/her MCO, the DHS caseworker must know which MCOs are open in the applicant's county. Always select the family's choice if possible.

All members of a family group in the same case/cat/sequence must have the same MCO (this also includes Medicaid individuals). Some individuals in a family may be eligible under a different case number and may be assigned a different MCO (such as SSI recipients, undocumented aliens receiving emergency Medicaid and presumptive eligibles). Some children

may be assigned TennCare Select if they receive SSI or have been in State custody. Always check the TennCare system to verify if any family member has an MCO already assigned.

An MCO may be closed for new members. However, if an individual is added to an existing TCS group, assign the same MCO already being used by the other group members. For example, when a newborn is added, assign the mother's MCO to the child. TennCare allows the same MCO to be given so that family groups all have the same MCO. This is called "case wrap."

MCO selections are designated on the AEIIM screen in ACCENT.

REPORTED CHANGES

TennCare Standard recipients must report changes in circumstances within 30 days of the change. DHS caseworkers must process the change within 10 days from the date the change is reported. Changes that may affect TCS eligibility status should be processed as soon as possible.

Case Closure based on a reported change

When a reported change requires case closure, the closure notice is produced by the TennCare Bureau. Each closure notice includes 20 days advance notice of closure to the enrollee. Because 20 days advance notice is required prior to closure, the end date of coverage will depend on when during the month the closure transaction from ACCENT is processed by TennCare.

Changes that may affect TCS eligibility

The types of changes that may affect TCS eligibility include:

- **Access to or receipt of comprehensive health insurance, including Medicare**. Be sure to determine if a child is eligible as a Grandfathered-in child. They may have access to insurance, but just have not obtained health insurance, and so remain eligible for TCS.

- **Receipt of TennCare Medicaid**. This includes SSI related Medicaid, as well as categories of Medicaid determined by DHS.

- **Incarceration**. Verify the name of the facility and that the enrollee is in a detention facility and not a residential or group home placement.

- **Moving out of state**. Obtain the out of state address if possible. The notice sent by TennCare will be sent to that new address if ACCENT is updated at the time of closure.

- **Income change** that causes family income to be at or over 200% FPL if the eligible child is currently open as uninsured. Processing for M.E. must begin at the point the change is reported.

- **Change in family composition.** When a required family member leaves the home, this could also cause a change of family income. Any income of the person who left must be

changed on AEITS so it is no longer counted (change the Y to N) prior to removing the person from the ACCENT case.

If possible, verify all of the above changes. The adult caretaker may choose to request closure in writing rather than verify access to or having insurance, for example. Such closure requests must always be in writing.

Income Changes

Reported increases or decreases in income must be accompanied by verification of the change. DHS will assist in obtaining verification upon request by the enrollee/family. If the change in income is due to a change in employment, verification of access to or having insurance must also be received.

Increases and decreases in income reported for other programs (such as Food Stamps) may also affect the premium amount for TCS. The change must be processed through the TennCare related screens on ACCENT in order for the change to update the premium amount, increase or decrease. The premium increase or decrease becomes effective on the day the change is processed by TennCare. Premium decreases will result in a credit to that case for the following month. Premium increases will be prorated for the number of days remaining in the current month and that amount added to the next premium notice mailed to the enrollee.

Grandfathered-In Children

Individuals (adults and children) who have or have access to health insurance are not eligible for TennCare Standard. However, children who are designated as Grandfathered-In Children may have access to health insurance and still remain eligible for TennCare Standard. Grandfathered-In Children who actually obtain health insurance are not eligible for TennCare Standard. In addition, Grandfathered-In Children must meet all other eligibility requirements.

Definition of Group

A Grandfathered-In child is one who:

- is not TennCare Medicaid eligible;
- was enrolled in TCS as of December 31, 2001, although they may have had access to group health insurance;
- have family income that falls below 200% FPL; and
- is under age19.

NOTE: Grandfathered-In policy does not apply to children who have had a break in TennCare Standard coverage.

Identification of Potential Eligibles

- Identifier of G code in the system in the 'insurance' field on AEITC screen.
- The date of birth field on interChange shows the child is not yet 19 years old.
- interChange shows continuous TennCare Standard eligibility and no Medicaid eligibility since December 31, 2001.

Changes which cause Ineligibility as a Grandfathered-in Child

There are several changes that may cause an existing Grandfathered-in Child to lose this status. They include:

- the child has insurance;
- the family group's income is at or above 200% FPL. Child may be processed for ME only if there is no insurance or access to insurance
- there is a break in TennCare Standard coverage, whether because of closure or the child becomes Medicaid eligible.

Once status as Grandfathered-in child is interrupted due to case closure, that status cannot be regained.

TENNCARE STANDARD SPEND DOWN

INTRODUCTION

Effective April 29, 2005, enrollment was closed for new applicants to certain TennCare Medicaid categories. The Medicaid enrollment closure means that non-pregnant adult applicants who applied for Medicaid after 4:30 PM on April 29, 2005 were not approved for eligibility in any closed category.

In approving a waiver amendment in March 2005, the Centers for Medicare and Medicaid Services (CMS) granted TennCare's request to disenroll currently eligible TennCare Standard adults, age 19 and over, and currently eligible non-pregnant Medically Needy Medicaid adults, age 21 and older. Disenrollment of these two (2) groups began in June 2005. Due to significant legal relief from previous restrictions imposed by the Grier Consent Decree, the process to disenroll all current non-pregnant Medically Needy Medicaid adults age 21 and older was stopped in August 2005, before any such disenrollments had been completed. Subsequently, the State began disenrolling non-pregnant Medically Needy adults who were dually eligible for Medicare and Medicaid and who, with the implementation of Medicare Part D drug coverage, had comprehensive coverage under Medicare. Some of these disenrollments were completed, but this disenrollment process was halted mid-stream (in May 2006) upon CMS' request. The eligibility of all remaining non-pregnant Medically Needy adults has been extended; however, no new applications have been accepted for these categories.

Tennessee extended the eligibility of the current Medically Needy Medicaid adults (with the exception of some Medically Needy duals) pending the development and approval of a new waiver-based program to provide coverage to non-pregnant adults with high medical expenses. The new program is designed to be very similar in eligibility and coverage to the Medicaid Medically Needy program. Unlike a Medicaid category, however, the new waiver-based category will be subject to an enrollment cap of 100,000 individuals and will have a managed enrollment process; and enrollees will not be covered for long term care services.

On October 5, 2007, CMS approved the State of Tennessee's request to amend the TennCare waiver to provide medical coverage to the non-pregnant adult Medically Needy population through the TennCare Standard Spend Down (SSD) category. Without this new SSD category, the non-pregnant adult population would otherwise be disenrolled from or ineligible for TennCare. DHS is responsible for determining eligibility for SSD.

Medical Assistance for Non-Pregnant Adults (age 21 and older)

Legal Base: CMS TennCare amendment approval effective October 5, 2007

SSD benefits are available to adults who:

- meet the technical eligibility requirements;

- are age 21 and older;
- are not pregnant;
- have income equal to or less than the appropriate Medically Needy Income Standard (MNIS) for the budget group size,

or

- have met the Spend Down requirement (refer to Budgeting section in this chapter); and
- have resources within the Medically Needy Medicaid resources limit based on the budget group size.

A pregnant caretaker or child under age 21 may **not** be included in this category.

Eligibility for SSD will be determined for currently eligible non-pregnant Medically Needy Medicaid adults during redetermination of eligibility. Steps 1-5 outline the redetermination process for currently eligible non-pregnant medically Needy Medicaid adults:

1. a currently Eligible Medically Needy Adult (EMNA) has been selected for SSD processing;
2. an Ex Parte review of the EMNA did not result in eligibility in an open category of Medicaid;
3. the EMNA individual is mailed a Request for Information (RFI) form;
4. the EMNA individual timely returns RFI; and
5. the EMNA individual is determined ineligible for Medicaid in an open category of Medicaid.

If, at step 5, an individual is determined ineligible in an open category of Medicaid, he/she will have eligibility determined in SSD.

SSD Categories

The following groups of individuals may be SSD eligible:

1. Aged, Blind and Disabled - Non-Institutionalized (MA-A, MA-B, or MA-D)

   The primary requirement, in addition to all other technical/financial requirements, is that the individual must be either:

   - Aged - 65 years or older, or
   - Blind - meeting the SSI criteria for blindness, or
   - Disabled - meeting the SSI criteria for disability

2. Aged, Blind and Disabled – Institutionalized (MA-A, MA-B, or MA-D)

   These individuals must meet all technical criteria for the categorically eligible institutionalized.

NOTE: If the institutionalized SSD individual's income exceeds the Medicaid Income Cap, he/she can "spend down" to receive SSD covered services. There are no HCBS services in SSD.

3. The Caretaker of a minor child

   To qualify for SSD as a caretaker, the caretaker must live with a closely related child in the home; or in a two (2) parent family with a minor child and one of the parents has:

   - lost his/her job, or
   - had work hours cut, or
   - a health or mental problem expected to last 30 days.

Eligibility Guidelines

Standard Spend Down (SSD) resembles the Medically Needy Medicaid program. Individuals must meet the same technical, financial and resource eligibility criteria that are required for the Medically Needy Medicaid program.

Listed below are the technical requirements that apply to this category and are covered in Chapter 2 of the TennCare Medicaid, TennCare Standard, and TennCare Standard Spend Down Manual.

- Prohibition against concurrent receipt of program benefits
- U.S. citizenship or qualifying alien status
- Tennessee residency
- Provision of or application for a Social Security number
- Prohibition against strike participation
- Disqualifying Living Arrangements
- Application for other benefits
- Assignment of third party medical support
- Financially responsible relatives

Eligibility Requirements

Legal Base: CMS TennCare amendment approval effective October 5, 2007

The following eligibility requirements do not have a separate chapter in this Manual and are applicable to the SSD category of coverage:

1. Age

   The SSD adult must have a verified age of 21 years or older and meet the requirements for disability, blindness, aged, or the caretaker of a minor child.

2. Deprivation

   The caretaker relative's needs may be included in the SSD aid group when the child is deprived of the support and care of one or both of his/her parents due to death, incapacity, unemployment of the primary wage earner, or continuous absence of at least one parent.

   Only one parent may be included as the caretaker; however, the other parent may be a second parent if eligibility is based on incapacity or unemployment of one parent.

   NOTE: The deprived child is not eligible for inclusion in the SSD aid group, but must be Medicaid eligible (including SSI, Poverty Level Income Standard or PLIS (MA-J) or Medically Needy eligible (MA-T).

   SSD budget group membership allows the deprived child's needs to be included in determining the assistance group's financial eligibility. Inclusion of the deprived child in the SSD budget group will increase both the Resource Reserve Limitation and the Medically Needy Income Standard.

3. Relationship

   Legal Base: CMS TennCare amendment approval effective October 5, 2007

   The SSD caretaker relative, who is age 21 or older, must live with a child who is within the degree of relationship specified by the law, in order to be included as a caretaker in SSD. Relationship verification is required to determine legal responsibility for budgeting purposes. Relatives who are within the "specified degree of relationship" are listed in Chapter 6 of the TennCare Medicaid, TennCare Standard, and TennCare Standard Spend Down Manual.

4. Dependency

   Dependency of a child must be determined in order to include an individual as an SSD caretaker in the aid group. A child under age 21 must live with the SSD caretaker who is age 21 or older, within the specified degree of relationship, **and** has primary responsibility for care and control of the child.

   a) Living in the Household

      This requirement is met when the child continuously shares the same home as the relative who bears the major responsibility for care, support and supervision of the child. Legal custody is not pertinent to the determination of eligibility and relationship. Where the child actually lives and who has care and control of the child are the determining factors.

   b) Care and Control

A relative is considered to have care and control of child when he/she has the major responsibility for parental obligations of day-to-day care, support, supervision and guidance for the child. These responsibilities may be carried out either alone or with another person living in the home. When the child lives with the relative, it is presumed that the relative has care and control of the child.

5. Resources

Resource policies concerning types, verifications, countable and excluded resources, and availability of assets can be found in Chapter 5: Resources, of the TennCare Medicaid, TennCare Standard, and TennCare Standard Spend Down Manual.

Count the resources of the following individuals:

- The resources of all persons included in the SSD budget group;

and

- the resources belonging to the financially responsible relative(s) of the budget group members, if the relative and group members are living together;

except for

- a family member who receives SSI, Families First or other public assistance;
- a stepparent; or
- the individually-owned resources of a spouse of a budget group member, who is not a budget group member.

6. Income

Income policies concerning countable/excluded/disregarded income, a discussion of earned and unearned income, verification methods, and budgeting methodology can be found in Chapters 3 & 4: Income and Treatment of Income, in the TennCare Medicaid, TennCare Standard, and TennCare Standard Spend Down Manual.

Count the income (except income that is subject to exclusion or disregard) of the following budget group members:

- all persons included in the SSD budget group;

- a Medically Needy, Medicaid-eligible child who is included in the budget group;

- the financially-responsible relative(s) of the budget group members, if the relative and group members are living together;

- a caretaker relative who is not a financially-responsible relative is not considered to be part of the budget group's countable income **unless** the caretaker relative requests inclusion in the budget group and he/she is otherwise eligible; and

- a spouse of a caretaker relative is considered when determining the needs of a caretaker relative who elects inclusion in the budget group. This income is deemed solely to the caretaker relative and is not available to the child(ren).

  EXCEPTION: Do not deem from a recipient receiving a VA pension.

  Do not count the income of a family member who receives SSI or Families First, or other public assistance.

APPLICATION PROCESSING

Eligibility Determination for Existing Medically Needy Adults (EMNA)

The eligibility determination review for the EMNA population will consist of a review of eligibility for SSD categories if not otherwise Medicaid eligible. Steps to be taken for termination of Medically Needy Medicaid coverage for existing non-pregnant Medically Needy adults (MA-A, MA-B, MA-D and MA-T), age 21 and older, and determination of their eligibility in an open category of Medicaid or the SSD program include:

- Ex Parte Reviews
- Requests for Information (RFIs)
- Requests for Verification
- Appeals

The eligibility determination review for the EMNA population will also include the following processes:

- Accommodations
- Severely Persistently Mentally Ill (SPMI) Outreach (ACCENT address match and follow-up contact by TennCare Partners Advocacy staff)
- Good Cause
- Undeliverable Mail
- Time Extension

The EMNA recipients will be selected for eligibility determination review on a "rolling basis". The TennCare Bureau and DHS will decide on a pre-determined number of EMNA recipients to be reviewed for Medicaid and/or SSD eligibility each month. Sufficient slots will be reserved in the SSD category to ensure all EMNA recipients who lose Medically Needy Medicaid coverage and are determined eligible for SSD will be enrolled in SSD. The SSD targeted enrollment cap of 100,000 includes new applicants and EMNA recipients who meet SSD eligibility criteria. If approved for SSD, EMNA recipients will receive 12 months of eligibility.

Ex Parte Reviews

DHS staff will conduct two (2) specific reviews to determine if an Existing Medically Needy Adult recipient would be eligible in an open category of Medicaid.

- SSA match of all EMNA recipients for Daniels and Pickle/Pass-along Medicaid.
- Open FS, FF and Medicaid case match of all EMNA recipients.

Request for Information (RFI)

Following the Ex-Parte Reviews a "brown" Request for Information (RFI) form, will be mailed to EMNA recipients advising them that their Medicaid eligibility category is ending and they will only remain eligible for TennCare if they qualify for an open Medicaid category or SSD. The mailing will request that they provide updated information regarding their circumstances through the RFI.

EMNA recipients will have until the last calendar day of the next month in which to respond to an RFI unless a special circumstance is acknowledged. If the RFI is received timely, the EMNA recipient will be considered for eligibility in an open category of Medicaid.

- If the RFI is received timely, the EMNA recipient will be considered for eligibility in an open category of Medicaid.
- If not Medicaid eligible, the EMNA recipient will be considered for SSD.
- If the EMNA recipient has an open Medically Needy Assistance Group on ACCENT and he/she does not return the RFI timely, the Medically Needy AG must be closed on ACCENT.

    - TennCare will notify DHS of the "No Response Termination"
    - DHS will close the Medically Needy Assistance Group on AEWAA using reason code 404.
    - DHS will mail the Medicaid closure notice.
    - TennCare will mail the No Response Termination notice.
    - The TennCare notice will provide the actual end date of coverage.

BUDGETING GUIDELINES

The new TennCare Standard Spend Down enrollment offers the opportunity for non-pregnant adults age 21 and older to have an eligibility determination made in the following SSD waiver categories: MA A, MA B, MA D, and MA T.

Guidelines for Standard Spend Down Eligibility

Individuals who are considered for TennCare Standard Spend Down eligibility are those who are currently eligible, non-pregnant Medically Needy Individuals who return timely Requests for Information.

Institutionalized (nursing home) and non-institutionalized (aged, blind, disabled or the caretaker of a deprived child) individuals may be considered for Standard Spend Down eligibility. Institutionalized individuals will not be eligible for long-term care coverage (vendor payments).

Standard Spend Down Budgeting Process

The Medically Needy Income Standard (MNIS) is the income standard used for non-institutionalized individuals. If income exceeds the MNIS, spend down must be met in order for coverage to be approved. There are no spend down requirements for non-institutionalized individuals with income less than the MNIS.

The Medicaid Income Cap (MIC) will be the income standard used for institutionalized individuals. This amount is currently $1911 effective January 1, 2008. If the individual's income is over the MIC and he/she has enough qualifying expenses to meet spend down, the individual may be eligible for SSD but will not receive coverage for long-term cost of care (vendor payments for nursing facility, Intermediate Care Facility/Mental Retardation or ICF/MR). HCBS individuals cannot receive SSD.

A budget period of one calendar month will be used. An individual who does not meet spend down eligibility at application determination will not be opened in order to meet spend down at a later date. (Reason code "040" should not be used.

Clarification of Acceptable Bills Used for Standard Spend Down

Medical Expenses for New Applicants

Medical bills incurred during the month of application (whether paid or unpaid) or medical bills incurred within three calendar months prior to the application month (whether paid or unpaid) may be used.

Payments made on an "old bill" during the application month may be used toward spend down, regardless of when the bill was incurred. Only the amount paid during the month of application may be counted.

NOTE: An "old bill" is any bill incurred more than three (3) months prior to the month of application.

Payments made on a bill during the application month should be used before using the incurred expenses to meet spend down.

- Any amount remaining from the incurred expense may be carried forward to be used for the next redetermination, if the expense is still owed.

- Any amount left over after the first redetermination may be carried over to be used for the second redetermination, if the expense is still owed.

- After the first year of eligibility, acceptable expenses will be limited to those incurred during the new application month and the three months prior to the new application month plus any unpaid medical expenses that were previously verified and documented as part of this new spend down process. The verified bills may continue to be carried over as long as the individual remains continuously eligible, the bills remain unpaid, and are not written off by the provider.

EXAMPLE #1: Tammy Jones incurred a medical expense in March 2008. Each month she pays $250 on this $5,000 expense. As a result of her pregnancy, Tammy filed an application at the local county office in October 2008. Due to the amount of her income, she must meet a $600 spend down in order to be eligible for MN Medicaid. She has no medical bills incurred during the three months prior to or during her application month of October. The $250 that she paid during October on her old bill is the only amount that can be counted toward her spend down. Since she does not have enough qualifying bills to meet a spend down, she would be denied for Medically Needy Medicaid.

EXAMPLE #2: **Susan Pike** incurred a $1000 medical expense in August, 2008. Susan filed an application at her local county office in October 2008 following news of her pregnancy. Based on her income, it would be necessary for her to have bills in the amount of $300 in order to be eligible for MN Medicaid. $300 of her $1000 medical expense can be used to fulfill her spend down obligation because the expense was incurred during the three months prior to the application month. $700 is left to be used for a future spend down, if it is still owed.

NOTE: This $1000 medical expense and the carry-over amount must be documented in the case record.

The next year she comes back for re-determination and states she is now 2 months pregnant. She still owes $700 from the medical expense she incurred during the three months prior to her initial application month. Her income has not changed but her AG has increased and her spend down is now $150 for this first review. She may use $150 from the $700 that is still owed. She is approved for another year and has $550 of the same bill remaining which may be used at the next re-determination if it is still owed, is not written off by the provider and she meets the requirements for MN Medicaid.

This same spend down policy applies to pregnant women and children who are not currently receiving Medically Needy Medicaid.

If the individual has income under the Medically Needy income standard at the next redetermination, the balance of the previously used incurred expense will no longer be carried forward for use. If the individual loses eligibility at any time, or if he ever qualifies as Exceptionally Eligible, the carryover ends.

EXAMPLE #3: An individual comes for another re-determination for MN Medicaid. However, this time she is no longer employed and has no income. Therefore, she is eligible for AFDC-MO. Because she is AFDC-MO eligible at this review, the carry-over of any unpaid medical bill will no longer be carried forward and will not be available to use for future re-determinations.

When an Exceptionally Eligible individual re-applies and a spend down must be met, no bills may be carried over because he did not have to meet spend down initially to qualify. He will be required to meet the "new applicant" criteria listed above.

If the balance of the incurred medical expense is insufficient to meet the spend down at redetermination, that balance will no longer be carried forward for use.

NOTE: Clear, concise documentation of CLRC is critical for the correct determination and application of medical bills for spend down eligibility.

Enrollees With Continuous Medically Needy Eligibility - Additional Considerations

Continuous Medically Needy eligibility means a period of eligibility with no effective break in coverage between TennCare Medicaid Medically Needy and Standard Spend Down. Other categories of eligibility (i.e. AFDC-MO and PLIS) do not count as continuous eligibility.

Continuous MN eligible individuals must have the following at redetermination to establish continued eligibility:

- Bills incurred during the month of application (whether paid or unpaid).
- Bills paid during the month of application (regardless of when the bill was incurred).
- Bills incurred during the three months prior to the month of application (whether paid or unpaid).
- Unpaid medical bills incurred during the application month or three months prior to the application month during the continuous MN eligibility period may include expenses not paid by TennCare as covered expenses. Examples of non-covered expenses are eyeglasses, hearing aids, walking devices for adults or costs in excess of TennCare coverage limits.

NOTE: Do not count bills paid during the three months prior to the application month **unless** the bills were also incurred during those same months.

Do not count any bills incurred **before** the three calendar months prior to the month of application unless payment is made on those bills during the month of application and only the amount paid during the month of application is counted; **OR** all of the following are met:

- The bills were previously verified and documented as part of meeting spend down,

- The individual has remained continuously eligible in a spend down category since that time,

- The individual has met spend down each period in order to qualify, and

- The bills remain unpaid and not written off by the provider. In this case, the carryover that has not been used for the purpose of qualifying for spend down can be applied. (The carryover expense may be an unused portion of a bill or an entire bill.

Using the old policy only for individuals currently eligible means that bills incurred before the three calendar months prior to the initial month of application may be carried over. However, only unpaid expenses that were previously verified and documented as part of the spend down process may be used. The individual may not bring in old bills that were not previously provided. The bills must remain unpaid and only the portions not used for a previous spend down may be counted toward a new period of eligibility.

EXAMPLE: An individual previously met a spend down for MA T on November 12, 2004. Coverage for this category will end November 2008. The individual comes for redetermination for MN eligibility in November. He does not have any unpaid medical expenses during the three months prior to his application month or during the application month. However, he has a carryover bill documented in running record for his case. The carryover bill has now been written off by the provider and may not be used for this redetermination. The individual has another old bill with him at the interview that was incurred at the same time as the one documented in running record. However, there is no documentation for the old bill that is presented. Even if this old bill remains unpaid, it cannot be used unless he makes a payment on it during this month of application. Only the amount of his payment may be counted toward spend down.

Continuous MN eligibility of one individual will count only for that individual and is not applicable to any other family member. (Other family members cannot be said to have continuous MN eligibility based on one individual's eligibility.)

Medical bills incurred by any family member (for which the individual is responsible) during the application month for continuous eligibility redetermination, the three months prior to the redetermination application month, or within three months prior to the date of initial application may be used. (See number 4 above for additional explanation)

EXAMPLE: An individual has had continuous MN eligibility from February 2005 through February of 2008. He has been selected for SSD determination and February 2008 is the month of his initial SSD determination. He has a $5000 medical bill incurred during October of 2004. This old bill was verified and documented in February 2005 running record as unpaid. $3000 of this bill was used to meet previous spend down. In February 2008, the worker verifies the bill remains unpaid and has not been written off. The individual must meet a new spend down of $1000 at the February 2008 SSD determination. Since the bill remains

unpaid, he may use $1000 to meet the initial SSD spend down and will have $1000 to carry over for a future spend down if the bill remains unpaid and has not been written off by the provider.

Special Issues - Standard Spend Down and continuous Medically Needy Eligibility

Determining eligibility for parents and children at different times

In some situations, one bill can be used to make a parent and child eligible at different times.

EXAMPLE: A ten-year old child incurred a $3,000 medical expense on August 1st. A Medicaid application was filed for this child on August 5th. Due to the amount of household income, the spend down amount would be $2,500. The child met spend down on the date of his application. His father who was listed on the ACCENT EMNA Database completed an RFI within the appropriate time period. The father's date of application was October 12th. Since his child's bill was incurred within three months of his application month, the father may use this same bill to meet spend down.

DDS DETERMINATION

Introduction

The Disability Determination Section (DDS) makes the disability determinations for the Social Security Administration's (SSA) processing of Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). DDS is composed of medical and vocational professionals and claims examiners. DDS will also determine the disabilities of individuals applying for the TennCare Standard Spend Down Program. DDS must make a determination when disability or blindness is alleged by a TennCare Standard Spend Down applicant except when the individual:

- receives Social Security Disability;
- receives Supplemental Security Income (SSI);
- receives Railroad Retirement disability benefits;
- receives Veteran's Benefits based on 100% disability; or
- has a previous DDS approval of disability.

If the applicant has been previously approved by DDS at any time, the approval will stand regardless of a review due date on DDS's decision sheet. The medical packet does not have to be resubmitted to DDS once approved unless:

- The applicant is now performing substantial gainful activity and the county does not use its discretion to terminate without a decision by DDS; **or**
- The applicant's disability no longer exists as confirmed by a more recent SSA denial of disability; **or**

- An application for Medicaid was filed prior to the date of SSI Medicaid eligibility and Medicaid is requested for the prior period

NOTE: The DHS caseworker is the link between the applicant and DDS. A conscientious and thorough completion of the medical/social narrative, based on the interview and observations of the applicant, and prompt submittal of that information to DDS enables the expeditious rendering of a decision.

Family Assistance (FA) Caseworker at DDS

Two (2) FA caseworkers will be housed at DDS to complete the case authorization process and take action on ACCENT when DDS makes a disability decision on a TennCare Standard Spend Down case. The DHS caseworker will:

- review the ACCENT case for continued technical and financial eligibility
- document CLRC with the DDS approval or denial
- authorize the case on AEWAA, (if the medical assistance group is the only open category of assistance in the case); and
    - issue the appropriate notice (see prior bullet) and DDS decision document to the applicant

NOTE: The county DHS office will need to ensure that changes are made timely and that CLRC is well-documented during the pending period when DDS is reviewing the case for disability.

DHS County Caseworker's Responsibility

The disability/blindness decision is made by DDS based in part on the information provided by the caseworker who initiates the process.

Compilation of the Medical Packet - The EW is responsible for compiling the medical packet with the information provided below in the following order:

- Medical Data Sheet is a preprinted form - (copies must be made) and must be completed by the caseworker and contain all the information requested:
    - the application date;
    - identifying information on the applicant;
    - the caseworker's name and telephone number;
    - note prior claims activity;
    - note 3rd party contacts; and

- a note should be added at the top of this page if the person claiming disability has Substantial Gainful Activity of $940 or more per month.

- Completed ACCENT Screens

Completion of the "AEIIM" (Individual Miscellaneous) screen by entering "y" under "Aged/Incap" flag starts the disability screen. The "AEIDP" Screen on ACCENT must be completed. On the "AEIDP" screen the date the case was referred to DDS must be filled in on this screen and this date should match the date on the TennCare Standard Spend Down data base.

The caseworker must complete the following screens in their entirety as they provide vital medical and social information, which DDS uses in conjunction with the medical reports and records to determine if disability exists.

IMPORTANT: After the data is entered on the ACCENT screens, the counselor should print the screens to create the hard copy of the medical packet that is to be mailed to DDS.

AEMII - Identification Data

Enter personal information regarding the applicant's name, address, height, weight, and educational level.

AEMIG - General Information

Enter information regarding the applicant's most recent employment, current living arrangement, SSA/SSI benefit status and receipt of vocational rehabilitation services within the past 12 months.

AEMIA - Additional Information

Enter information regarding the individual's appearance, attitude and physical/mental condition. If a face-to-face interview cannot be conducted with the applicant, provide an explanation of why the applicant was not interviewed under "other pertinent information".

AEMIM - Medical Information

Enter the information regarding the individual's disability impairment; how impairments limit daily activities, medications taken, and need for attendant care in addition to previous illnesses and/or surgery.

AEMIT - Medical Treatment

Enter names and address of medical providers who have treated the applicant within the last 2 years and include the date(s) of treatment. DDS will use this information to request medical/psychological/psychiatric reports from the identified medical providers.

AEMIV - Vocational Information

Enter information concerning the applicant's work experience history beginning with the most recent job and listing any job worked in the past 15 years. This should include daily hours worked, and job requirement for walking, standing, sitting, lifting and carrying.

- If applicable, the following should be completed:

  - the DDS Chest Pain Questionnaire
  - the DDS Seizure Questionnaire
  - The applicant must complete one (1) "HIPAA Authorization for Release of Information" per provider along with two (2) extra release forms.

  EXAMPLE: The applicant is being treated by eight (8) doctors and has been hospitalized in three (3) different hospitals. This applicant has 11 providers and will need to sign and date a release form for each provider (11) plus two extra forms for a total of thirteen (13) HIPAA Authorization for Release of Information forms. The signed and dated release forms must be included in the packet.

- To be valid, the forms must be originals, copies or faxes cannot be used. If there is a legitimate reason that an applicant cannot sign the form a 3rd party may sign the form, but a note should be written on the release of information form, giving the reason this is being done. If the applicant has a Power of Attorney, that person can sign the form. If the applicant cannot write, but can sign, have them put an "X" in the signature line, and have this witnessed by a 3rd party.

  EXAMPLE of when the form can be signed by a third party: the person is in a coma or so impaired that they cannot sign the form.

- Before a TennCare Standard Spend Down case is sent to DDS, all points of eligibility, technical, resources, and financial other than disability must be verified.

  If the case would be denied for any other reason not related to disability, it should NOT be sent to DDS. (An example: The customer has provided all needed verifications and does not have medical bills to meet spend down. The case should be denied for not meeting the spend down amount and **not** sent to DDS. Even if DDS determined disability existed, the case would still not be approved).

- The medical packet is mailed to:

  Disability Determination Section

P. O. Box 245
Nashville, TN 37202-9655

- An email is sent to Laura.F.Clark@ssa.gov and toDonna.L.Miller@state.tn.us that includes the following information:

  - District (by number)
  - County (by name)
  - Name of client
  - SSN
  - Case/Category/Sequence Number
  - Date of application
  - Date sent to DDS (should be the same date entered in CLRC as well as the same date the email is sent to the county)

- Time Frames for gathering and submission of Medical Packet

  Disability applications must be processed to a decision of approval or denial within the 90 days of receipt of the application. DDS will authorize medical-physical-psychological examinations and schedule appointments, in addition to securing medical reports/records from treating medical providers. The initial medical packet must be completed as quickly as possible by the caseworker and submitted to DDS (**within 1 day of the eligibility determination**).

DDS Responsibilities

Upon receipt of the medical file from the caseworker, the claims examiner in DDS will:

- Collect additional Information from medical providers and other agencies such as:

  - Physicians
  - Hospital
  - other medical institutions
  - Vocational Rehabilitation
  - Veteran's Administration (Regional Office)
  - United Mine Workers Association.

- The information must contain the following:

  - Diagnosis based on objective/clinical finding in the examination or treatment process
  - Prognosis with and without treatment
  - Current treatment(s) being administered;

- Authorize medical examinations and physicians, psychiatrists or other specialist and request hospital records and other information;

- Schedule appointments for examinations and notify the Medicaid applicant;

- Compile the medical record using information submitted by the caseworker and medical information secured by DDS;

- Make a decision regarding disability in collaboration with other medical and vocational information;

- When DDS makes the disability determination, DDS staff will notify the DHS caseworker located at DDS;

- The caseworker will take action on ACCENT (if the medical assistance group is the only open category of assistance in the case) and issue the appropriate notice and DDS decision document to the applicant; and

- Retain the medical packet at DDS.

Overdue Disability Determinations
An application for the Standard Spend Down program must be processed within the 45 and/or 90 days (disability) timeliness standards. Timeliness is of the utmost importance. Therefore, there cannot be any unjustified delay at any point of the process.

DDS Timeliness Standard

DHS is required to make a Standard Spend Down (SSD) disability determination within the 90 day time frame for applicants who have applied for SSD. There are some exceptions to the 90 day processing time frame. The exceptions may include the following situations:

- Heart attack (decision cannot be made before 90 days from the date of the heart attack)

- Stroke (decision cannot be made before 90 days from date of the stroke)

- Severe head injury (decision cannot be made before 90 days from date of the head injury)

Associated Claims

There may be times when an SSD applicant has also applied for Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI) with the Social Security Administration (SSA). The applicant who has applied for both SSD and SSA has an "**associated claim**". In most instances, the decision on the SSD application and the Social Security disability application is made at the same time.

In other situations, the decisions are rendered separately. DDS makes a decision on the SSD application but no decision has been made on the associated Social Security disability claim. The separate decisions are usually made because one of the following has occurred:

- SSD/SSA applicant reports additional medical sources or changes in medical condition and this report is made at the last minute, or
- Disability Determination Service (DDS) examiner staff discovers additional medical provider sources at the last minute and must request additional medical records, or
- Internal DDS Quality Assurance reviewer disagrees with the examiner's decision and additional development is required, or
- Regional SSA office disagrees with the Social Security disability decision and additional development is required.

When one or more of the unusual circumstances listed above occurs and DDS makes a decision on the SSD application, but no decision has been made on the associated claim; the DDS decision on the SSD application is referred to as a "**contingent**" decision. The DDS decision could either be a "contingent" approval or a "contingent" denial. The decision made by DDS could be reversed based on the SSA Social Security disability determination.

The Family Assistance case worker at DDS will approve or deny the SSD based on the "contingent" decision made by DDS if the medical assistance group is the only open category of assistance in the case) and the SSD applicant will be mailed a "contingent" approval or denial notice. This "contingent notice" will inform the SSD applicant that the Social Security disability decision will ultimately determine whether he/she is eligible for SSD. The contingent notices will also include SSA appeal language.

Listed below are examples of what would happen when a "contingent" approval decision is made and SSA later makes its decision:

- DDS approves SSD and Social Security approves the SSDI claim; individual remains eligible for SSD.
- DDS approves SSD and Social Security denies SSDI; SSD must be terminated (after all SSA appeal rights are exhausted).
- DDS approves SSD and Social Security approves SSI; SSD will be terminated. Individual will be approved for SSI Medicaid.
- DDS approves SSD and Social Security denies SSI; SSD must be terminated (after all SSA appeal rights are exhausted).

Listed below are examples of what would happen when a "contingent" denial decision is made and SSA later makes its decision:

- DDS denies SSD and Social Security approves SSDI; SSD will be approved.
- DDS denies SSD and Social Security denies SSDI. If individual is an EMNA with open Medically Needy benefits, the MN coverage remains open until all SSA appeal rights are exhausted.

- DDS denies SSD and Social Security approves SSI; the individual will be approved for SSI Medicaid. If the SSD individual has open MN coverage, the MN coverage must be terminated.
- DDS denies SSD and Social Security also denies SSI; MN Medicaid must be terminated for EMNA (after all SSA appeal rights are exhausted).

Thorough documentation of the DHS case record is required for every DDS decision including documentation of exceptions and associated claims.

DDS Disability Decision

The DDS decision is binding on the Family Assistance case worker's decision of eligibility. However, when there are "associated claims" the disability decisions made by the Social Security Administration (SSA) are binding on the DDS decision. The SSA decision could result in the FA case worker completing a second action on the SSD case. See "Associated Claims" section for further details.

Substantial Gainful Activity (SGA) Defined

SGA means performance of significant physical or mental activities in work for pay or profit, or in work of a type generally performed for pay or profit. Significant activities are useful in the accomplishment of a job or the operation of a business and have economic value. Work may be substantial even it is performed on a seasonal or part time basis, or even if the individual does less, is paid less, or has less responsibility than in previous work. Work activity is gainful if it is the kind of work usually done for pay, whether in cash or in kind, or for profit, whether or not a profit is realized.

Activities involving self-care, household task, unpaid training, hobbies, therapy, school attendance, clubs, social programs, etc., are not generally considered to be SGA.

SGA is current employment with average earnings of $940 effective January 1, 2008 or more per month (this amount can change if SSA updates it standard). Any work activity the applicant has or is performing should be addressed in completion of the AEMIV screen.

NOTE to Caseworker: On the top of the tracking sheet that is sent with the packet to DDS, note the person alleging disability has SGA of $940 or more.

Deprivation

To include a caretaker relative's needs in the SSD aid group; the child must be deprived of the support and care of one or both of his parents due to:

- Death,
- Continuous absence of at least one parent,
- Incapacity, or
- Unemployment of the primary wage earner.

Only one parent may be included as caretaker; however, the other parent may be a second parent if eligibility is based on incapacity or unemployment of one parent.

NOTE: The deprived child is not eligible for SSD aid group membership but must be Medicaid eligible (including SSI, Poverty Level Income Standard or PLIS, or Medically Needy.

SSD budget group membership allows the deprived child's needs to be included in determining the group's financial eligibility which is reflected in an increase in both the Resource Reserve Limitation and the Medically Needy Income Standard.

INCAPACITY DETERMINATION

Introduction

Incapacity is deemed to exist when one parent has a physical or mental defect, illness, or impairment.

The incapacity shall be supported by competent medical testimony and must impair or eliminate the parent's ability to support or care for the otherwise eligible child and be expected to last for a period of at least 30 days.

AND

The incapacity may be permanent or temporary but must restrict the parent's occupational or child care activities to the extent that he or she cannot give the child support or care.

When deprivation is based on incapacity, at least one caretaker must be found to be incapacitated for one or both caretakers to receive SSD. The Medical Evaluation Unit (MEU) makes the incapacity determinations for DHS. MEU is composed of DHS staff including:

- Program Manager
- Program Coordinator
- 2 Registered Nurses (RNs)
- 7 Program Specialists
- 1 Administrative Secretary
- 1 Clerk

MEU will determine incapacity for **certain** relative caretakers applying for SSD and MEU staff will approve or deny the SSD case on ACCENT when a decision has been made (if the medical assistance group is the only open category of assistance in the case).

MEU must make a determination when incapacity has been alleged by one parent in a two parent SSD household that also includes a minor child for whom Medicaid is requested or already received. Applications not requiring a MEU incapacity decision are:

- 1 parent in a 2 parent home receives Social Security Disability
- 1 parent in a 2 parent home receives Supplemental Security Income (SSI)
- 1 parent in a 2 parent home receives Railroad Retirement disability benefits
- 1 parent in a 2 parent home receives Veteran's Benefits based on 100% disability.

MEU and ACCENT Systems Processing

Staff in the MEU will take action on ACCENT when the MEU makes an incapacity decision on a TennCare Standard Spend Down case. MEU will:

- review the ACCENT case for continued technical and financial eligibility;
- document CLRC with the MEU approval or denial;
- authorize (approve or deny) the case on AEWAA (if the medical assistance group is the only open category of assistance in the case); and
- issue the appropriate notice (see prior bullet) and MEU decision document to the applicant.

NOTE: The county DHS office will need to ensure that changes are made timely and that CLRC is well-documented during the pending period when MEU is reviewing the case for incapacity.

The DHS caseworker is the link between the applicant and MEU. A conscientious and thorough completion of the medical/social narrative, based on the interview and observations of the applicant, and prompt submittal of that information to MEU enables the expeditious rendering of a decision.

FA Caseworker's Responsibility

The incapacity decision made by the MEU is based, in part, on the information provided by the caseworker who initiates the process.

Compilation of the Medical Packet

The EW is responsible for compiling the medical packet with the information provided below in the order listed.

- Medical Data Sheet

  Is a preprinted form (copies may be made) and must be completed by the caseworker and contain all the information requested, including:

  - The application date
  - Identifying information on the applicant

- Caseworker's name and telephone number
- Prior MEU claims activity and 3rd party contacts
- A note added to the top of this page if the person claiming disability has Substantial Gainful Activity of $940 (effective 1/1/08) or more a month.

- Completed ACCENT Screens

  Completion of the "AEIIM" Screen, Individual Miscellaneous by entering "y" under "Aged/Incap" flag starts the disability screen. The "AEIDP" Screen on ACCENT must be completed.

  The case worker must complete the following screens in their entirety as they provide vital medical and social information, which MEU uses in conjunction with the medical reports and records to determine if disability exists. After the data is entered on the ACCENT screens, prints are made of the screens below and are included with the medical packet.

  AEMII - "Identification Data"

  Enter personal information regarding the applicant's name, address, height, weight, and educational level

  AEMIG - "General Information"

  Enter information regarding the applicant's most recent employment, current living arrangement, SSA/SSI benefit status and receipt of vocational rehabilitation services within the past 12 months

  AEMIA - "Additional Information"

  Enter information regarding the individual's appearance, attitude and physical/mental condition. If a face-to-face interview cannot be conducted with the applicant, provide an explanation of why the applicant was not interviewed under "other pertinent information"

  AEMIM - "Medical Information"

  Enter the information regarding the individual's disability impairment; how impairments limit daily activities, medications taken, and need for attendant care in addition to previous illnesses and/or surgery

  AEMIT - "Medical Treatment

  Enter names and address of medical providers who have treated the applicant within the last 2 years and include the date(s) of treatment. The MEU will use this information to request medical/psychological/psychiatric reports from the identified medical providers

AEMIV - "Vocational Information"

Enter information concerning the applicant's work experience history beginning with the most recent job and listing any job worked in the past 15 years. This should include daily hours worked, and job requirement for walking, standing, sitting, lifting and carrying.

- Forms

  - If applicable, the Chest Pain Questionnaire should be completed.

  - If applicable, the Seizure Questionnaire should be completed.

  - The applicant must complete one (1) "HIPAA Authorization for Release of Information" per provider along with two (2) extra release forms. EXAMPLE: the applicant is being treated by eight (8) doctors and has been hospitalized in three (3) different hospitals. This applicant has 11 providers and will need to sign and date a release form for each provider (11) plus two extra forms for a total of thirteen (13) HIPAA Authorization for Release of Information forms. The signed and dated release forms must be included in the packet.

  - To be valid, these forms must be originals; copies or faxes cannot be used.

  - If there is a legitimate reason that an applicant cannot sign the form, a 3rd party may sign the form, but a note should be written on the release of information form, giving the reason this is being done.

  - If the applicant has a Power of Attorney, that person can sign the form.

  - If the applicant cannot write, but can sign, have them but an "X" in the signature line, and have this witnessed by a 3rd party.

    EXAMPLE: A 3rd party can sign the release forms when the person is in a coma or so impaired that they cannot sign the form

Before a Standard Spend Down case is sent to MEU, all points of eligibility, technical, resources, and financial other than incapacity must be verified. **If the case would be denied for any other reason not related to incapacity, it should NOT be sent to MEU.** (An example: The customer has provided all needed verifications and does not have medical bills to meet the spend down amount. The case should be denied for not meeting the spend down amount and not sent to MEU. Even if MEU determined disability existed, the case would still not be approved).

Medical packet submitted to MEU

Mail the completed medical packet and the HIPPA release forms to:

Medical Evaluation Unit
Tennessee Department of Human Services
10th Floor Citizens Plaza Building
Nashville, TN 37243-1403

Time frames for gathering and submission of Medical Packet Incapacity applications must be processed to a decision of approval or denial within 45 days of receipt of the application.

The MEU will authorize medical/physical/psychological examinations and schedule appointments in addition to securing medical reports/records from treating medical providers. The initial medical packet must be completed as quickly as possible by the EW and submitted to MEU within one (1) day of the eligibility determination.

The following steps should be taken for any SSD incapacity applications that are processed, when a medical social narrative is required to be sent to MEU:

1. Enter the date the MA-T medical information is sent to MEU in the ACCENT CLRC documentation screen.

2. E-mail Jennifer Styke in Medicaid Policy (via GroupWise) at the point the medical is mailed and include:

    - District (by number)
    - County (by name)
    - Name of client
    - SSN
    - Case/Category/Sequence number
    - Date of Application
    - Date sent to MEU – should be the same date you enter in CLRC as well as the same day the email is sent by the county.

MEU Responsibilities

MEU Staff

Upon receipt of the medical file from the county caseworker, the MEU staff will:

- collect information from medical providers and other agencies such as

    - Physicians
    - Hospital
    - Other medical institutions
    - Vocational Rehabilitation

- Veteran's Administration (Regional Office)
- United Mine Workers Association

The information must contain diagnosis based on objective/clinical finding in the examination or treatment process, prognosis with and without treatment, and current treatment(s) being administered

- Authorize medical examinations and physicians, psychiatrists or other specialist and request hospital records and other information.

- Schedule appointments for examinations and notify the Medicaid applicant.

- Compiles the medical record using information submitted by the caseworker and medical information secured by MEU.

- Make a decision regarding incapacity in collaboration with other medical and vocational information.

- When MEU makes the incapacity determination, MEU staff will approve or deny on ACCENT (if the medical assistance group is the only open category of assistance in the case) and update the Standard Spend Down data system.

- Mail the decision sheet (see prior bullet) to the applicant.

- Retain one copy of the decision sheet in MEU.

- Mail the medical packet to the county office.

Overdue Incapacity Determinations

An application for the Standard Spend Down program that requires an incapacity decision must be processed within the 45 day timeliness standard. Timeliness is of the utmost importance. Therefore, there cannot be any unjustified delay at any point of the process.

MEU Incapacity Decision

The decision of MEU is binding on the county decision of eligibility based on incapacity.

Substantial Gainful Activity (SGA) Defined

SGA means performance of significant physical or mental activities in work for pay or profit, or in work of a type generally performed for pay or profit. Significant activities are useful in the accomplishment of a job or the operation of a business and have economic value. Work may be substantial even it is performed on a seasonal or part time basis, or even if the individual does less, is paid less, or has less responsibility than in previous work. Work activity is gainful if it is the kind of work usually done for pay, whether in cash or in kind, or for profit, whether or not a

profit is realized. Activities involving self-care, household task, unpaid training, hobbies, therapy, school attendance, clubs, social programs, etc., are not generally considered to be SGA.

SGA is current employment with average earnings of $940 effective January 1, 2008 or more per month (this amount can change if SSA updates its standard). Any work activity the applicant has performed or is performing should be addressed in completion of the AEMIV screen.

NOTE TO EW: On the top of the tracking sheet that is sent with the packet to MEU, note the person alleging incapacity has SGA of $940 or more per month.

Unemployed Parent Criteria

Tennessee has eliminated the 100-hour rule as criteria for an unemployed parent in a two-person household except in situations where the caretaker in an AFDC- MO family marries a non-recipient.

When deprivation is based on unemployed parent criteria, the principal wage earner must be unemployed for at least 30 days.

The Principal Wage Earner is defined as the parent (in a two-parent home) with the greater amount of earnings in a 24-month period including the month immediately preceding the application month. If both parents have the same amount of income, the Eligibility Counselor along with the family will designate the principal wage earner.

Under-employment is defined as a job paying minimum wage for less than 35 hours per week, which is offered by a private employer, self-employment, JTPS or other work training programs under contract to, or in agreement with, the Department of Human Services. Under-employment of the principal wage earner is a basis for deprivation.

A Bona Fide Job Offer is defined as a job paying at least minimum wage for at least 35 hours per week, which is offered by a private employer, through self-employment, JTPA, or other work training programs under contract, or in agreement with, the Department of Human Services.
Good cause for failure to accept employment includes illness of a more serious nature than a common cold.

Good cause may be granted for illness of an assistance group parent or child, when the principal wage earner is the only available caregiver or:

- there is lack of transportation,
- the job is not within the documented physical or mental capability of the
- individual,
- the wage is less than the minimum wage,

- the job poses an unreasonable risk to health and safety of the person.

ACCENT

New ACCENT Database

ACCENT has been modified so that the existing Medically Needy adults can be processed correctly. A new database has been added to ACCENT to hold information about these individuals:

- ACCENT Existing Medically Needy Adult Database, hereafter referred to as the EMNA database

Institutionalized individuals may be eligible for TennCare Standard Spend Down, but cannot receive coverage for long term care services (vendor payments). Institutionalized individuals (nursing home residents or Home and Community Based Services enrollees) may receive long term care services if they are categorically eligible for Medicaid.

ACCENT Existing Medically Needy Adult Database

At the time of their review, ACCENT will load existing Medically Needy adults to the EMNA Database so that they can be evaluated for Standard Spend Down eligibility. The EMNA individuals will be processed in a manner similar to the TennCare Standard Disenrollment process (including entering information on OATS). The EMNA database will include data about each EMNA individual, including, but not limited to, name, date of birth, SSN, recipient ID, enrollment type code, begin enrollment date, end enrollment date, and eligibility end date. Existing Medically Needy individuals must remain open until their review process period when they will be evaluated for eligibility in Medicaid and Standard Spend Down.

Accent Grouping

If an EMNA individual is determined eligible and has a spouse in the household who is not on the EMNA Database, but groups as "EA" in the SSD group, the caseworker must check TennCare interChange for the spouse to determine if the spouse is currently eligible for MN. If the applicant's spouse is currently eligible for MN, the caseworker must not close the applicant's spouse even though he/she is not on the ACCENT EMNA DB.

If the eligible couple is in an open MN group, fiats must be done to separate the couple into two separate groups. ACCENT groups the couple together in one MA group with both as "EA" participants. You must leave the individual who is not on the EMNA DB in the current sequence, changing the spouse's participation status to "NA." Create another sequence for the spouse who is on the EMNA DB as "EA" and the other spouse as "NA." Take appropriate action on the new group. Leave open the assistance unit for the spouse who is not up for renewal.

If the eligible couple is in a closed MN group, ACCENT groups the couple in one MA group with both participants as "EA." You must change the participation status of the spouse who is

not up for renewal to "NA." Do not create a group for the eligible spouse who is not on the EMNA DB until he/she is up for renewal. Take appropriate action on the group for the spouse who is applying for SSD at this time.

If the applicant's spouse is not currently eligible for Medically Needy and is not on the EMNA DB, staff must fiat the SSD group to change the spouse's participation status to "DS" in the eligible individual's AG. Take appropriate action on the group.

Staff must use the ACCENT AEOAG screen to delete and create groups to accomplish the fiat procedures above. If the spouse does not group with a participation status of "EA" in the applicant's group, the caseworker does not have to fiat the MA A, MA B, or MA D group.

The existence of the EMNA database allows ACCENT to recognize the EMNA individuals and to process eligibility for the EMNA individuals. For instance, ACCENT compares the application date to the begin and end enrollment dates on the ACCENT EMNA database. If the application date is after the end enrollment date ACCENT will process the applicant like it would a non-EMNA individual who is not on ACCENT EMNA database and will not allow the caseworker to approve the individual for TennCare Standard Spend Down benefits.

An individual who applies after the end enrollment date but prior to the coverage end date, which is set by TennCare when they mail the "No Response" termination notice, can be processed as an EMNA applicant. We have established special procedures to allow the coverage end date to be changed on ACCENT until we can accomplish an ACCENT modification. This special process can also be used by Appeals staff if the coverage end date needs to be changed for correct EMNA processing following an appeal.

The special process for changing the coverage end date is:

- The Program Supervisor or appropriate Appeals staff must send an email request to Donna York (donna,york@state.tn.us) with copies to Marcia Garner and Helen Sawyers.

- The email should include the individual's name, SSN, date of birth, and the date to which the coverage end date needs to be changed.
- Donna York will notify the person who requested the change when the change has been made.

Modifications to Existing ACCENT Screens

A new enrollment code field, "SSD CI," has been added to ARCR, "STATEWIDE CLEARANCE RESULTS." The possible values are:

- 01 = Medically Needy Non-Institutional(existing MA A, MA B, MA D, or MA T)

- 02 = SSD Institutionalized Individual (existing MA A, MA B, or MA D)

Several new fields have been added to IQIG, "INDIVIDUAL GENERAL." They are:

- "SSD CI" is a new enrollment code field. The values are the same as those listed above for the same field on ARCR.

- "PERIOD BEG" displays the begin enrollment date which is the RFI mail date.

- "END" displays the end enrollment date, which is the last date that the individual can be evaluated for Standard Spend Down eligibility.

- "ORIG END" displays the original enrollment end date received from TennCare.

- "ACT TKN" displays one of the following:

    - Blank – No Response
    - OP – Open
    - PE – Pending
    - CL – Closed
    - DE – Denied
    - NG – Not Grouped

The new enrollment code field "SSD CI" displays on IQCM, "Case Members History." The values for the "SSD CI" field are the same as those listed for the "SSD CI" field on ARCR and IQIG.

ACCENT Processing Changes

In ACCENT, the TennCare Standard Spend Down coverage groups for adults will still look like they are Medicaid categories (MA A, MA B, MA D, and MA T). They will be processed through ACCENT and authorized on AEWAA, not on AEITG.

All applications (RFIs) for EMNA individuals must be entered on ARAD when the RFI is received. The county staff will complete ARAD for the EMNA individuals.

If an EMNA individual is processed in an open case, ARAD must not be denied until after the disposition of the SSD benefits. In this situation, the caseworker must deny ARAD for reason 580, "We have your application. We will see if you can get benefits in your open case."

NOTE: Using this reason code suppresses the ARAD denial notice.

All EMNA applications must be processed in AECSQ or AEORE mode. This is very **important** in order for ACCENT to generate correct SSD notices.

When the Task Force staff determines that the SSD application has resulted in ACCENT's forming a MA D or MA B group, and the case is being sent to DDS for a disability decision, the MA D or MA B group must be left pending until the disability decision is made.
The Task Force staff must enter "?" in the "VR" field for "limiting Physical/Mental Factor" on AEIDP so the MA D or MA B group will pend as long as the disability determination is pending.

NOTE: The "?" must not be removed until the DDS disability decision is received and the case is disposed.

The MA D or MA B group must remain pending until that time.
If there are other assistance groups in the case, they can be disposed (opened, closed, or denied) while the MA D or MA B remains pending.

If a Standard Spend Down assistance group contains more than one "EA" adult, the caseworker/supervisor must fiat the group into separate groups for each EMNA individual. (See examples below.) Separate groups must be created to ensure that each EMNA individual receives the appropriate TennCare Standard Spend Down notices. (Notice changes and new reason codes will be covered in a separate section.)

EXAMPLE 1: Mom, Dad, and their two children group in MA T. Both the parents are on the ACCENT EMNA Database. Field staff must perform the fiat to change Mom's and Dad's participation code to "NA" in the children's MA T AG. Field staff must also create separate MA T AGs for Mom and Dad with "EA" participation status codes. The final groups should be:

MA T 01:	Mom	Dad	Child 1	Child 2
	NA	NA	EC	EC

MA T 02:	Mom	Dad	Child 1	Child 2
	EA	NA	NC	NC

MA T 03	Mom	Dad	Child 1	Child 2
	NA	EA	NC	NC

EXAMPLE 2: Husband and wife are both over age 65 and are both on the ACCENT EMNA Database. They group in MA A. Field staff must fiat the individuals so that the final groups will be as follows:

MA A 01:	Wife	Husband
	EA	NA

MA A 02:	Wife	Husband
	NA	EA

In both examples 1 and 2, the caseworker should open or deny each AG as appropriate.

Institutionalized EMNA individuals who are approved for SSD are not eligible for vendor payments. Caseworkers should not enter any medical bill as type "CC" on AEFME for these individuals. The absence of a type "CC" medical expense allows ACCENT to approve medical assistance only with no vendor payments. The institutional cost of care should be entered as type "OT" if appropriate. Institutionalized individuals must be categorically eligible in order to be eligible for vendor payments.

For EMNA individuals who have an open Medically Needy assistance group and who do not submit the reapplication form, the caseworker should:

- close the open medically needy group on AEWAA for reason 404, "You did not cooperate with us on the review/recertification of your eligibility."

  NOTE: The EMNA individual's ACCENT assistance group should not be closed until TennCare has sent the individual a "No Response" notice.

- The field staff should use the report GTA598FA, "TennCare Disenrollment No RFI Received" to determine when TennCare has taken this action, so that the ACCENT open medically needy group can be closed at the appropriate time.

EMNA applicants who meet spend down for one month will receive 365 days of coverage when the group is opened, unless the case is a contingent case that has been approved for SSD and an SSA decision reverses the eligibility and the SSA decision is upheld in the event of an appeal by the applicant. After their SSD coverage has been verified on the TennCare Interchange system, the county field staff should:

- close the open SSD assistance group on AEWAA, using reason code 460, "Spend down case is being closed. TennCare coverage is open for 12 months.

- ACCENT will suppress the closure notice.

- If an action is later taken on these cases, the county field staff should not enter a sign date on AEFPY.

There are no changes to the procedures for processing applications when they contain no one on the ACCENT EMNA database. See AIA-05-06, "ACCENT Modifications for TennCare/Medicaid Closed Enrollment," dated April 29, 2005.

New AEWAA Edits

EMNA database individuals are not eligible for TennCare Standard Spend Down benefits if they apply after their coverage end date.

New error messages:

- "1519 – Two Adults in AG; Fiat Into Separate Groups" displays on AEWAA if a MA A, MA B, MA D, or MA T assistance group contains more than one non-institutionalized "EA" adult who is in an open MEDICALLY NEEDY or SSD group

- "1523 – AG Must Be Closed/Denied with 497" displays on AEWAA when a caseworker attempts to close or deny MA A, MA B, MA D, or MA T with a reason code other than 497, "You did not show us enough medical bills to get Standard Spend Down," and the AG does not pass at least one month's eligibility. You can enter other reason codes along with "497" if appropriate.

Notices

There are three (3) new ACCENT reason codes:

- 170 – "You have Standard Spend Down for now. This coverage could be closed if SSA denies your claim for disability."

- 497 – "You did not show us enough medical bills to get Standard Spend Down."

- 575 – "DHS denied your application for disability. If SSA says you are disabled, DHS may approve Standard Spend Down.

Reason code 040, "TennCare Medicaid will start when you show us enough medical bills to meet your spend down," will no longer be a valid code for use on AEWAA.

Do not open a Standard Spend Down group that is failing eligibility for all months.

There are some changes to client notices based on the new TennCare Standard Spend Down eligibility determination. The following is a synopsis of the new notices that will be generated for individuals who are on the ACCENT SSD Call-In Database:

- **AE01-D8 and AE04-D8** – "Ungrouped" Medicaid Denial for Individuals on the ACCENT EMNA DB. EMNA DB individuals who do not group in any Medicaid group or who group in only the Standard Spend Down groups (MA T, MA A, MA B, and MA D) will get this new notice. No specific reason codes are displayed on this notice. The yellow (English) or the green (Spanish) appeals enclosure and the blue multi-language enclosure will be mailed with this notice. All other ACCENT no;tices will be suppressed for individuals on the EMNA DB.

- Multiple notices will be generated to the same individual. TennCare will produce the SSD approval, denial, or termination notices.

NOTICE ENCLOSURES - TennCare Standard Spend Down enclosures are:

- TennCare "Multi-Language," enclosure,
- TennCare "Do You Need Special Help?" and
- TennCare "Legal Services".

APPEALS POLICY

Types of Appeals Associated with the SSD Process

When an individual's eligibility for participation in a public assistance program is determined by DHS and the individual is dissatisfied with the action taken by DHS, he/she has the right to appeal for a fair hearing by an impartial hearing official.

MA Denial

There are also several reasons for an application to be denied Medicaid coverage. This list is not all inclusive.

- Applicant is over the income and/or resource limits.
- Applicant does not meet citizenship requirements.
- Applicant did not group for a Medicaid category.

Eligible Medically Needy Adults Denial

Existing EMNAs must be reviewed for eligibility in the SSD program if they are ineligible for all other categories of Medicaid. The reasons for denial are similar to those listed for the SSD and MA Denials. For example:

- Applicant has been denied incapacity.
- Applicant's disability has been denied by DDS;
- Applicant is over the income standard and has no medical bills or insufficient medical bills to help him/her meet spend down;
- Applicant is over the resource limits;
- Applicant is unable to prove citizenship based on new guidelines; and
- Applicant did not submit their application prior to termination date.

Contingent Decisions

SSD applicants who also have associated claims may appeal the DDS with DHS and may also appeal the Social Security disability decision with SSA.

The DHS appeal may be filed due to:

- Applicant has been denied as disabled by DDS.

The SSA appeal may be filed due to:

- Applicant has been denied SSDI by SSA, or
- Applicant has been denied SSI by SSA.

NOTE: The SSA decision is binding on DHS/DDS.

Appeals Process for SSD Related Appeals

The Division of Appeals and Hearings will review any appeal requests by an applicant regarding the SSD program. An individual has the right to file an appeal but the appeal must be filed within the prescribed time limit.

Timeliness

The applicant has **40 days from the date of the notice that he/she is appealing to file a timely appeal** with DHS. The date of the notice can be found in ACCENT on CNHS and CNHD screens.

If there are no recent notices, check ACCENT (AEWAA) for the last transaction date based on the appeal issue as identified by the appellant. For denied applications, the latest dates can be used if assessing timeliness.

If the appeal is timely filed, the Conciliation Unit will determine if the appellant is alleging a valid factual dispute.

Valid Factual Dispute

To be fair hearable, the appeal must allege a valid factual dispute which means that if the facts alleged by the individual are true, the Department would be prevented from taking the action that is being appealed. If the dispute is with agency policy, it is not fair hearable.

All MA appeals identified by the Conciliation Unit in the Division of Appeals and Hearings as non-fair hearable are forwarded to the Conciliation Attorney for review. CLRC and the Appeals Resolution Tracking System (ARTS) will be documented with any actions by Appeals staff.

The Conciliation Attorney in the Division of Appeals and Hearings will review the appeal. If the Conciliation Attorney determines that the appellant has not presented a valid factual dispute, a Notice will be sent to the appellant giving him/her 10 days to provide information that will explain why he/she disagrees with the facts in his/her case. If the appellant fails to respond within 10 days, or responds but does not provide information to show he/she is disputing the facts in the case, a second notice is sent to the appellant closing the appeal because he/she did not allege a valid factual dispute.

Non-Fair Hearable Examples

- Appellant has no medical bills to help them meet spend down and admits that he/she does not have any medical bills

- Appellant's only claim is that he/she cannot afford the health insurance offered on his/her job.

Fair Hearable Example

- Appellant was denied because he/she did not have medical bills to meet a spend down obligation. Appellant alleges he/she presented sufficient medical bills at the time of the application to meet the spend down requirement.

- Appellant disagrees with the medical decision of non-disability by DDS. Appellant states he/she has medical records to support his/her claim of disability.

- Appellant disputes the calculation of resources in his/her SSD/Medicaid case and alleges that his/her resources are within the limit.

Continuation of Benefits

EMNA adults will be eligible for continuation of benefits if they appeal within 20 days of the date of the notice that identified the action with which they are dissatisfied, or effective date of action, whichever is later.

Appeal Resolution

The time allowable to process an appeal varies depending on the program area. It is important to always keep in mind that the time count starts when the person orally requests an appeal or the date the written request is received by the County Office, Family Assistance Service Center, or the Division of Appeals and Hearings.

The timeliness of all appeal decisions is of utmost importance. Therefore, there cannot be any unjustified delay at any point of the process. A delay of a few days could mean the difference between an Appeal being timely decided and one that is overdue. Overdue appeals are not tolerated unless the delay is beyond the control of the Hearing Officer. It is crucial that appeals flow through the system smoothly and timely at all steps of the appeal process.

The processing time limit means that a Final Order must be issued before the allotted number of days has expired. The appeal resolution timeframe for TennCare Standard Spend Down appeals is 90 days.

INSTITUTIONALIZED INDIVIDUALS

Categorically Eligible - Institutionalized individuals may be eligible for SSD but will not receive vendor payments for long term care services. To be eligible for such vendor payments, institutionalized individuals must have income less than the Medicaid Income Cap or establish an approved Qualified Income Trust (QIT) and will then be considered.

BENEFIT PACKAGE

The benefit package for SSD will be the same as the benefit package currently approved for TennCare's adult Medicaid population, except institutionalized SSD enrollees will not receive coverage for Long Term Care (including nursing facility and ICF/MR).

Medicare recipients approved for SSD will receive the same Medicare cost sharing that is covered for dual eligible Medicaid pregnant women and children, which at present includes deductibles and co-pays.

APPENDIX A

LIFE EXPECTANCY TABLE – FEMALES

Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy
0	78.79	40	40.61	80	9.11
1	78.42	41	39.66	81	8.58
2	77.48	42	38.72	82	8.06
3	76.51	43	37.78	83	7.56
4	75.54	44	36.85	84	7.08
5	74.56	45	35.92	85	6.63
6	73.57	46	35.00	86	6.20
7	72.59	47	.4.08	87	5.79
8	71.60	48	33.17	88	5.41
9	70.61	49	32.27	89	5.05
10	69.62	50	31.37	90	4.71
11	68.63	51	30.48	91	4.40
12	67.64	52	29.60	92	4.11
13	66.65	53	28.72	93	3.84
14	65.67	54	27.86	94	3.59
15	64.68	55	27.00	95	3.36
16	63.71	56	26.15	96	3.16
17	62.74	57	25.31	97	2.97
18	61.77	58	24.48	98	2.80
19	60.80	59	23.67	99	2.64
20	59.83	60	22.86	100	2.48
21	58.86	61	22.06	101	2.34
22	57.89	62	21.27	102	2.20
23	56.92	63	20.49	103	2.06
24	55.95	64	19.72	104	1.93
25	54.98	65	18.96	105	1.81
26	54.02	66	18.21	106	1.69
27	53.05	67	17.48	107	1.58
28	52.08	68	16.76	108	1.48
29	51.12	69	16.04	109	1.38
30	50.15	70	15.35	110	1.28
31	49.19	71	14.66	111	1.19
32	48.23	72	13.99	112	1.10
33	47.27	73	13.33	113	1.02
34	46.31	74	12.68	114	.96
35	45.35	75	12.05	115	.89
36	44.40	76	11.43	116	.83
37	43.45	77	10.83	117	.77
38	42.50	78	10.24	118	.71
39	41.55	79	9.67	119	.66

LIFE EXPECTANCY TABLE -- MALES

Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy
0	71.80	40	35.05	80	6.98
1	71.53	41	34.15	81	6.59
2	70.58	42	33.26	82	6.21
3	69.62	43	32.37	83	5.85
4	68.65	44	31.49	84	5.51
5	67.67	45	30.61	85	5.19
6	66.69	46	29.74	86	4.89
7	65.71	47	28.88	87	4.61
8	64.73	48	28.02	88	4.34
9	63.74	49	27.17	89	4.09
10	62.75	50	26.32	90	3.86
11	61.76	51	25.48	91	3.64
12	60.78	52	24.65	92	3.43
13	59.79	53	23.82	93	3.24
14	58.82	54	23.01	94	3.06
15	57.85	55	22.21	95	2.90
16	56.91	56	21.43	96	2.74
17	55.97	57	20.66	97	2.60
18	55.05	58	19.90	98	2.47
19	54.13	59	19.15	99	2.34
20	53.21	60	18.42	100	2.22
21	52.29	61	17.71	101	2.11
22	51.38	62	16.99	102	1.99
23	50.46	63	16.30	103	1.89
24	49.55	64	15.62	104	1.78
25	48.63	65	14.96	105	1.68
26	47.72	66	14.32	106	1.59
27	46.80	67	13.70	107	1.50
28	45.88	68	13.09	108	1.41
29	44.97	69	12.50	109	1.33
30	44.06	70	11.92	110	1.25
31	43.15	71	11.35	111	1.17
32	42.24	72	10.80	112	1.10
33	41.33	73	10.27	113	1.02
34	40.23	74	9.27	114	.96
35	39.52	75	9.24	115	.89
36	38.62	76	8.76	116	.83
37	37.73	77	8.29	117	.77
38	36.83	78	7.83	118	.71
39	35.94	79	7.40	119	.66

PLIS DESK GUIDE - EFFECTIVE 3/1/08

AG SIZE	ANNUAL	[QMB] 100%	[SLMB] 120%	133%	[QI] 135%	185%	200%
1	$10,400	867	1040	1153	1170	1603	1733
2	$14,000	1167	1400	1552	1575	2158	2333
3	$17,600	1467	1760	1951	1980	2713	2933
4	$21,200	1767	2120	2350	2385	3268	3533
5	$24,800	2067	2480	2749	2790	3823	4133
6	$28,400	2367	2840	3148	3195	4378	4733
7	$32,000	2667	3200	3547	3600	4933	5333
8	$35,600	2967	3560	3946	4005	5488	5933
9	$39,200	3267	3920	4345	4410	6043	6533
10	$42,800	3567	4280	4744	4815	6598	7133
11	$46,400	3867	4640	5143	5220	7153	7733
12	$50,000	4167	5000	5542	5625	7708	8333
13	$53,600	4467	5360	5941	6030	8263	8933
14	$57,200	4767	5720	6340	6435	8818	9533
15	$60,800	5067	6080	6739	6840	9373	10133
16	$64,400	5367	6440	7138	7245	9928	10733
17	$68,000	5667	6800	7537	7650	10483	11333
18	$71,600	5967	7160	7936	8055	11038	11933
19	$75,200	6267	7520	8335	8460	11593	12533
20	$78,800	6567	7880	8734	8865	12148	13133
21	$82,400	6867	8240	9133	9270	12703	13733
22	$86,000	7167	8600	9532	9675	13258	14333
23	$89,600	7467	8960	9931	10080	13813	14933
24	$93,200	7767	9320	10330	10485	14368	15533

LEGEND

- **100% PLIS** = QMB and children ages 6 – 19th birthday
- **120% PLIS** = SLMB
- **133% PLIS** = Children ages 1 – 6th birthday
- **135% PLIS** = Qualifying Individuals with income >120% <135% and no Medicaid or TennCare coverage
- **185% PLIS** = Pregnant women and infants to age 1 and Transitional Medicaid
- **200% PLIS =**QDWI

MONTHLY PREMIUM & INCOME TABLE – EFFECTIVE MARCH 1, 2007

Individual Premium	$0	$20.00	$35.00	$100.00	$150.00
Family Premium	$0	$40.00	$70.00	$250.00	$375.00
Percentage of Poverty	0% - 99%	100% - 149%	150% - 199%	200% - 249%	250% - 299%
Family Size	Monthly Income	Monthly Income	Monthly Income	Monthly Income	Monthly Income
1	$0 - $850	$851 - $1,275	$1,276 - $1,701	$1,702 - $2,126	$2,127 - $2,552
2	$0 - $1,140	$1,141 - $1,710	$1,711 - $2,281	$2,282 - $2,851	$2,852 - $3,422
3	$0 - $1,430	$1,431 - $2,145	$2,146 - $2,861	$2,862 - $3,576	$3,577 - $4,292
4	$0 - $1,720	$1,721 - $2,580	$2,581 - $3,441	$3,442 - $4,301	$4,302 - $5,162
5	$0 - $2,010	$2,011 - $3,015	$3,016 - $4,021	$4,022 - $5,026	$5,027 - $6,032
6	$0 - $2,300	$2, 301 - $3,450	$3,451 - $4,601	$4,602 - $5,751	$5,752 - $6,902
7	$0 - $2,590	$2,591 - $3,885	$3,886 - $5,181	$5,182 - $6,476	$6,477 - $7,772
8	$0 - $2,880	$2,881 - $4,320	$4,321 - $5,761	$5,762 - $7,201	$7,202 - $8,642
9	$0 - $3,170	$3,171 - $4,755	$4,756 - $6,341	$6,342 - $7,926	$7,927 - $9,512
10	$0 - $3,460	$3,461 - $5,190	$5,191 - $6,921	$6,922 - $8,651	$8,652 - $10,382
Individual Premium	$200.00	$250.00	$350.00	$450.00	$550.00
Family Premium	$500.00	$625.00	$875.00	$1,125.00	$1,375.00
Percentage of Poverty	300% - 349%	350% - 399%	400% - 499%	500% - 599%	600% - Over
Family Size	Monthly Income	Monthly Income	Monthly Income	Monthly Income	Monthly Income
1	$2,553 - $2,977	$2,978 - $3,402	$3,403 - $4,253	$4,254 - $5,104	$5,105 – Over
2	$3,423 - $3,992	$3,993 - $4,562	$4,563 - $5,703	$5,704 - $6,844	$6,845 – Over
3	$4,293 - $5,007	$5,008 - $5,722	$5,723 - $7,153	$7,154 - $8,584	$8,585 – Over
4	$5,163 - $6,022	$6,023 - $6,882	$6,883 - $8,603	$8,604 - $10,324	$10,325 – Over
5	$6,033 - $7,037	$7,038 - $8,042	$8,043 - $10,053	$10,054 - $12,064	$12,065 – Over
6	$6,903 - $8,052	$8,053 - $9,202	$9,203 - $11,503	$11,504 - $13,804	$13,805 – Over
7	$7,773 - $9,067	$9,068 - $10,362	$10,363 - $12,953	$12,954 - $15,544	$15,545 – Over
8	$8,643 - $10,082	$10,083 - $11,522	$11,523 - $14,403	$14,404- $17,284	$17,285 – Over
9	$9,513 - $11,097	$11,098 - $12,682	$12,683 - $15,853	$15,854 - $19,024	$19,025 – Over
10	$10,383 - $12,112	$12,113 - $13,842	$13,843 - $17,303	$17,304 - $20,764	$20,765 – Over

030104

Monthly Premium & Income Table – Effective March 1, 2007

Individual Premium	$0	$20.00	$35.00	$100.00	$150.00
Family Premium	$0	$40.00	$70.00	$250.00	$375.00
% of Poverty	0% - 99%	100% - 149%	150% - 199%	200% - 249%	250% - 299%
Family Size	Monthly Income	Monthly Income	Monthly Income	Monthly Income	Monthly Income
11	0 – $3,750	$3,751 – 5,625	$5,626 – 7,501	$7,502 – 9,376	$9,377 - 11,252
12	0 – $4,040	$4,041 – 6,060	$6,061 – 8,081	$8,082 – 10,101	$10,102 - 12,122
13	0 – $4,330	$4,331 – 6,495	$6,496 – 8,661	$8,662 – 10,826	$10,827 - 12,993
14	0 – $4,620	$4,621 – 6,930	$6,931 – 9,241	$9,242 – 11,551	$11,552 -13,862
15	0 – $4,910	$4,911 – 7,365	$7,366 – 9,821	$9,822 – 12,276	$12,277 - 14,732
16	0 – $5,200	$5,201 – 7,800	$7,801 – 10,401	$10,402 – 13,001	$13,002 - 15,602
17	0 – $5,490	$5,491 – 8,235	$8,236 – 10,981	$10,982 – 13,726	$13,727- 16,472
18	0 – $5,780	$5,781 – 8,670	$8,671 – 11,561	$11,562 – 14,451	$14,452 – 17,342
19	0 – $6,070	$6,071 – 9,105	$9,106 – 12,141	$12,142 – 15,176	$15,177 - 18,212
20	0 – $6,360	$6,361 – 9,540	$9,541 – 12,721	$12,722 – 15,901	$15,902 - 19,082
21	0 – $6,650	$6,651 – 9,975	$9,976 – 13,301	$13,302 – 16,626	$16,627 - 19,952
22	0 – $6,940	$6,941 – 10,410	$10,411 – 13,881	$13,882 – 17,351	$17,352 - 20,822
23	0 – $7,230	$7,231 – 10,845	$10,846 – 14,461	$14,462 – 18,076	$18,077 - 21,692
24	0 – $7,520	$7,521 – 11,280	$11,281 – 15,041	$15,042 – 18,801	$18,802 - 22,562
Individual Premium	$200.00	$250.00	$350.00	$450.00	$550.00
Family Premium	$500.00	$625.00	$875.00	$1,125.00	$1,375.00
% of Poverty	300% - 349%	350% - 399%	400% - 499%	500% - 599%	600% - Over
Family Size	Monthly Income	Monthly Income	Monthly Income	Monthly Income	Monthly Income
11	$11,253 –13,127	$13,128 - 15,002	$15,003 - 18,753	$18,754 – 22,504	$22,505 - Over
12	$12,123 - 14,142	$14,143 - 16,162	$16,163 - 20,203	$20,204 – 24,244	$24,245 - Over
13	$12,993 - 15,157	$15,158 - 17,322	$17,323 - 21,653	$21,654 – 25,984	$25,985 - Over
14	$13,863 - 16,172	$16,173 - 18,482	$18,483 - 23,103	$23,104 – 27,724	$27,725 - Over
15	$14,733 - 17,187	$17,188 - 19,642	$19,643 - 24,553	$24,554 – 29,464	$29,465 - Over
16	$15,603 - 18,202	$18,203 - 20,802	$20,803 - 26,003	$26,004 – 31,204	$31,205 - Over
17	$16,473 - 19,217	$19,218 - 21,962	$21,963 - 27,453	$27,454 – 32,944	$32,945 - Over
18	$17,343 - 20,232	$20,233 - 23,122	$23,123 - 28,903	$28,904 – 34,684	$34,685 - Over
19	$18,213 - 21,247	$21,248 - 24,282	$24,283 - 30,353	$30,354 – 36,424	$36,425 - Over
20	$19,083 - 22,262	$22,263 - 25,442	$25,443 - 31,803	$31,804 – 38,164	$38,165 - Over
21	$19,953 - 23,277	$23,278 - 26,602	$26,603 - 33,253	$33,254 – 39,904	$39,905 - Over
22	$20,823 - 24,292	$24,293 - 27,762	$27,763 - 34,703	$34,704 – 41,644	$41,645 - Over
23	$21,693 - 25,307	$25,308 - 28,922	$28,923 - 36,153	$36,154 – 43,384	$43,385 - Over
24	$22,563 - 26,322	$26,323 - 30,082	$30,083 - 37,603	$37,604 – 45,124	$45,125 - Over

APPENDIX B

COST ITEMS FOR SKILLED NURSING FACILITIES (SNF) AND INTERMEDIATE CARE FACILITIES (ICF)

Tennessee's Medical Plan identifies the following items as SNF/ICF cost items. Do not allow a deduction for payment of these types of expenses as a necessary (uncovered) Medical expense in the determination of patient liability.

A

Alcohol
Antacids and suspensions
Applicators: cotton tipped, swab-ees
Arm: slings, infusion board
Aspirin

B

Bags: drainage
Bandages: elastic, cohesive
Bandaids
Basin
Bed frame equipment
Bed pans
Bed rails
Beds, water
Benozoin aerosol
Blood infusion sets
Blood pressure equipment
Bibs: plastic

C

Canes
Catheters: dwelling, nasal, plugs and trays, suctions
Commode chairs
Cotton balls
Cradle: folding foot, heat
Crutches

D

Decubitus Ulcer Pads
Deodorants
Dietary supplements used for tubes/oral feeding such as high nitrogen diet these are food not drugs and are not allowed as prescriptions
Douche bag
Drainage sets, bags
Drugs: non-legend e.g. laxatives, stock (except insulin)

E

Enema: fleet's, cans

F

Feeding tubes
Folding foot cradle

G

Gastric feeding units
Gauze
Gloves (sterile & nonsterile)

H

Handfeeding

Heat cradle
Heating pads
Heel protector
Hot pack machine

I

Ice bags
Incontinency care items: pads, pants
Infusion arm boards
Inhalation therapy supplies: including intermittent positive pressure breathing machines (I.P.P.B.)
Invalid rings
Irrigation bulbs

J

Jelly, lubricating

K

Kaolin solution

L

Laundry services (does not includes personal)
Laxatives
Linens (extra)
Lubricating jelly

M

Massages (by nurse)
Mattresses: air, P.R., floatation
Medical equipment, durable
Medicine droppers
Milk of magnesia
Mineral oil
Mouthwashes

N

Nail care (toes and fingers)
Needles: various sizes, hypodermic, scalps, vein
Nursing care and services: (1) general including administrative of oxygen and relate; medications; (2) restorative
Nursing Supplies and dressings

O

Oil: antipruitic mineral
Ointments: non-prescription
Overhead trapeze equipment
Oxygen equipment: oxygen, tents, masks, concentrators
Pads: heating, flotation, ABD, decubitus ulcer, composite, alcohol, eye, incontinency
Pants, incontinency
Pectin solution
Pitchers, water
Plasters
Power, baby
Pumps: Aspiration, suction

R

Restraints
Room and Board

S

Sand bags
Scalpel
Sheepskin
Slings, arm
Soap: retention, green
Social Services (medical)
Specimen cups, bottles
Sponges
Sterile pads
Stomach tubes
Suppositories
Surgical dressings, pads, tape
Suture removal kits
Syringes: all sizes, disposable, asepto

T

Tape: non-allergic, butterfly , for lab test, adhesive
Testing sets & refills
Thermometers
Tissue, bedside
Tongue depressors
Traction equipment
Trays: service, irrigation, I.V., suture, dressing
Tube feeding: nasal
Tubes: dressing, surgical, drainage, nasal, gastric, stomach, I.V., suction

U

Underpads: chucks, disposable,
Urinals: male, female
Urinary drainage tub & bottle
Urological solutions

W

Walkers
Waterbeds
Wheelchairs